

		FOR BHF USE					

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

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.

<p>I. IDPH License ID Number: <u>0050492</u></p> <p>Facility Name: <u>Heritage Health Dwight</u></p> <p>Address: <u>300 East Mazon Ave</u> <u>Dwight</u> <u>60420</u> Number City Zip Code</p> <p>County: <u>Livingston</u></p> <p>Telephone Number: <u>(815) 584-1240</u> Fax # ()</p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>3/6/1992</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>David M Underwood</u> (Date) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Title) <u>EVP & CFO</u></td> </tr> <tr> <td>(Signed) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) <u>()</u> Fax # () _____</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>David M Underwood</u> (Date) _____	Paid Preparer	(Title) <u>EVP & CFO</u>	(Signed) _____	(Print Name and Title) _____	(Firm Name & Address) _____		(Telephone) <u>()</u> Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
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	(Print Name and Title) _____																																		
	(Firm Name & Address) _____																																		
	(Telephone) <u>()</u> Fax # () _____																																		
<p>In the event there are further questions about this report, please contact: Name: <u>David M Underwood</u> Telephone Number: <u>(309)8237135</u> Email Address: _____</p>	<p>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</p>																																		

Facility Name & ID Number Heritage Health Dwight

0050492 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	92	Skilled (SNF)	92	33,672	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	92	TOTALS	92	33,672	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	14,013	7,227	2,923	24,163	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,013	7,227	2,923	24,163	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.76%

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

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

I. On what date did you start providing long term care at this location?
Date started 3/6/1992

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 92 and days of care provided 2,923

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Heritage Health Dwight # 0050492 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	283,871	28,852	6,640	319,363		319,363	4,489	323,852		1
2	Food Purchase		199,165		199,165		199,165	(16)	199,149		2
3	Housekeeping	86,502	39,856		126,358		126,358	5,984	132,342		3
4	Laundry	58,026	14,788		72,814		72,814	428	73,242		4
5	Heat and Other Utilities			106,332	106,332		106,332	1,425	107,757		5
6	Maintenance	96,828	68,650	97,584	263,062		263,062	17,464	280,526		6
7	Other (specify):*										7
8	TOTAL General Services	525,227	351,311	210,556	1,087,094		1,087,094	29,774	1,116,868		8
	B. Health Care and Programs										
9	Medical Director			10,800	10,800		10,800		10,800		9
10	Nursing and Medical Records	1,838,287	201,710	76,580	2,116,577	(5,530)	2,111,047	(6)	2,111,041		10
10a	Therapy		257,560	11,468	269,028	(262,024)	7,004		7,004		10a
11	Activities	87,212	10,108		97,320		97,320	5	97,325		11
12	Social Services	41,489		2,907	44,396		44,396	128	44,524		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,966,988	469,378	101,755	2,538,121	(267,554)	2,270,567	127	2,270,694		16
	C. General Administration										
17	Administrative	88,083			88,083		88,083		88,083		17
18	Directors Fees										18
19	Professional Services			325,019	325,019		325,019	(305,902)	19,117		19
20	Dues, Fees, Subscriptions & Promotions			209,376	209,376	(182,579)	26,797	(15,871)	10,926		20
21	Clerical & General Office Expenses	271,023	33,627	6,581	311,231		311,231	382,962	694,193		21
22	Employee Benefits & Payroll Taxes			443,013	443,013		443,013	38,566	481,579		22
23	Inservice Training & Education			36	36		36	1,177	1,213		23
24	Travel and Seminar			2,717	2,717		2,717	2,282	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			50,980	50,980		50,980	63,889	114,869		26
27	Other (specify):* Lost resident items			35,649	35,649		35,649	(35,388)	261		27
28	TOTAL General Administration	359,106	33,627	1,073,371	1,466,104	(182,579)	1,283,525	131,715	1,415,240		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,851,321	854,316	1,385,682	5,091,319	(450,133)	4,641,186	161,616	4,802,802		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 Dwight

#0050492

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			161,824	161,824		161,824	21,588	183,412			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			45,780	45,780		45,780	(3,547)	42,233			32
33	Real Estate Taxes			57,474	57,474		57,474		57,474			33
34	Rent-Facility & Grounds			220,500	220,500		220,500	6,647	227,147			34
35	Rent-Equipment & Vehicles			45,917	45,917		45,917	11,766	57,683			35
36	Other (specify):*											36
37	TOTAL Ownership			531,495	531,495		531,495	36,454	567,949			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			499,087	499,087	267,554	766,641	176,465	943,106			39
40	Barber and Beauty Shops			1,179	1,179		1,179		1,179			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					182,579	182,579		182,579			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			500,266	500,266	450,133	950,399	176,465	1,126,864			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,851,321	854,316	2,417,443	6,123,080		6,123,080	374,535	6,497,615			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 Dwight

0050492

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	(5,970)			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	(4,731)			17
18	Fines and Penalties				18
19	Entertainment	(2,507)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,090)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(35,388)			24
25	Fund Raising, Advertising and Promotional	(12,024)			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)	\$ (64,710)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	439,245		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 439,245		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 374,535		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	
							52

Heritage Health Dwight

ID# 0050492

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		(4,090)	19	11
12		(5,970)	32	12
13		(35,388)	27	13
14		(12,024)	20	14
15		(4,731)	20	15
16		0	27	16
17		(2,507)	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	(64,710)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Dwight# 0050492

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	4,489	0	0	0	0	0	0	0	0	4,489	1
2	Food Purchase	0	0	(16)	0	0	0	0	0	0	0	0	(16)	2
3	Housekeeping	0	0	5,984	0	0	0	0	0	0	0	0	5,984	3
4	Laundry	0	0	428	0	0	0	0	0	0	0	0	428	4
5	Heat and Other Utilities	0	0	1,425	0	0	0	0	0	0	0	0	1,425	5
6	Maintenance	0	0	17,464	0	0	0	0	0	0	0	0	17,464	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	29,774	0	0	0	0	0	0	0	0	29,774	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	(23,250)	23,244	0	0	0	0	0	0	0	0	(6)	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	128	0	0	0	0	0	0	0	0	128	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	(23,250)	23,377	0	0	0	0	0	0	0	0	127	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	(4,090)	(317,048)	15,236	0	0	0	0	0	0	0	0	(305,902)	19
20	Fees, Subscriptions & Promotions	(16,755)	0	884	0	0	0	0	0	0	0	0	(15,871)	20
21	Clerical & General Office Expenses	0	0	382,962	0	0	0	0	0	0	0	0	382,962	21
22	Employee Benefits & Payroll Taxes	0	0	38,566	0	0	0	0	0	0	0	0	38,566	22
23	Inservice Training & Education	0	(36)	1,213	0	0	0	0	0	0	0	0	1,177	23
24	Travel and Seminar	(2,507)	0	4,789	0	0	0	0	0	0	0	0	2,282	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	63,889	0	0	0	0	0	0	0	0	63,889	26
27	Other (specify):*	(35,388)	0	0	0	0	0	0	0	0	0	0	(35,388)	27
28	TOTAL General Administration	(58,740)	(317,084)	507,539	0	0	0	0	0	0	0	0	131,715	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(58,740)	(340,334)	560,690	0	0	0	0	0	0	0	0	161,616	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Dwight

0050492

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	21,588	0	0	0	0	0	0	0	21,588	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,970)	0	0	2,423	0	0	0	0	0	0	0	(3,547)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	6,647	0	0	0	0	0	0	0	6,647	34
35	Rent-Equipment & Vehicles	0	0	0	11,766	0	0	0	0	0	0	0	11,766	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(5,970)	0	0	42,424	0	0	0	0	0	0	0	36,454	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	176,292	0	173	0	0	0	0	0	0	0	176,465	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	176,292	0	173	0	0	0	0	0	0	0	176,465	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(64,710)	(164,042)	560,690	42,597	0	0	0	0	0	0	0	374,535	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	10 Adjustment for Related Organiza	\$	GreenTree Pharmacy		\$(23,250)	\$(23,250)	1
2	V	23 Adjustment for Related Organization		GreenTree Pharmacy		(36)	(36)	2
3	V	39 Adjustment for Related Organization		GreenTree Pharmacy		176,292	176,292	3
4	V	19 Adjustment for Related Organization	317,048	Heritage Operations Group, LLC			(317,048)	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 317,048			\$ 153,006	\$ * (164,042)	14

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

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. 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		\$ 4,489	\$ 4,489
16	V	2 Food Purchase		Heritage Operations Group		(16)	(16)
17	V	3 Housekeeping		Heritage Operations Group		5,984	5,984
18	V	4 Laundry		Heritage Operations Group		428	428
19	V	5 Heat & Other Utilities		Heritage Operations Group		1,425	1,425
20	V	6 Maintenance		Heritage Operations Group		17,464	17,464
21	V	7 Other		Heritage Operations Group		0	
22	V	9 Medical Director		Heritage Operations Group		0	
23	V	10 Nursing & Medical Records		Heritage Operations Group		23,244	23,244
24	V	11 Activities		Heritage Operations Group		5	5
25	V	12 Social Service		Heritage Operations Group		128	128
26	V	13 Nurse Aide Training		Heritage Operations Group		0	
27	V	14 Program Transportation		Heritage Operations Group		0	
28	V	15 Other		Heritage Operations Group		0	
29	V	17 Administrative		Heritage Operations Group		0	
30	V	18 Directors Fees		Heritage Operations Group		0	
31	V	19 Professional Services		Heritage Operations Group		15,236	15,236
32	V	20 Fees, Subscription, Promotions		Heritage Operations Group		884	884
33	V	21 Clerical & General Office Expenses		Heritage Operations Group		382,962	382,962
34	V	22 Employee Benefits & Payroll Taxes		Heritage Operations Group		38,566	38,566
35	V	23 Inservice Training & Education		Heritage Operations Group		1,213	1,213
36	V	24 Travel and Seminar		Heritage Operations Group		4,789	4,789
37	V	25 Other Admin. Staff Transportation		Heritage Operations Group		0	
38	V	26 Insurance-Prop.Liab.Malpract		Heritage Operations Group		63,889	63,889
39	Total		\$			\$ 560,690	\$ * 560,690

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

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. 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	27	\$	Heritage Operations Group		\$ 0	\$	15	
16	V	30		Heritage Operations Group		21,588	21,588	16	
17	V	31		Heritage Operations Group		0		17	
18	V	32		Heritage Operations Group		2,423	2,423	18	
19	V	33		Heritage Operations Group		0		19	
20	V	34		Heritage Operations Group		6,647	6,647	20	
21	V	35		Heritage Operations Group		11,766	11,766	21	
22	V	36		Heritage Operations Group		0		22	
23	V	38		Heritage Operations Group		0		23	
24	V	39		Heritage Operations Group		173	173	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		\$			\$ 42,597	\$ *	42,597	39

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

Facility Name & ID Number

Heritage Health Dwight

0050492

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	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 Dwight

0050492

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 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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,493	25	\$ 121,634	\$ 121,338	92	\$ 4,489	1
2	2	Food Purchase	Beds	2,493	25	(423)	0	92	(16)	2
3	3	Housekeeping	Beds	2,493	25	162,156	0	92	5,984	3
4	4	Laundry	Beds	2,493	25	11,591	0	92	428	4
5	5	Heat & Other Utilities	Beds	2,493	25	38,605	0	92	1,425	5
6	6	Maintenance	Beds	2,493	25	473,233	88,567	92	17,464	6
7	7	Other	Beds	2,493	25	0	0	92	0	7
8	9	Medical Director	Beds	2,493	25	0	0	92	0	8
9	10	Nursing & Medical Records	Beds	2,493	25	629,872	35,401	92	23,244	9
10	11	Activities	Beds	2,493	25	129	0	92	5	10
11	12	Social Service	Beds	2,493	25	3,478	3,478	92	128	11
12	13	Nurse Aide Training	Beds	2,493	25	0	0	92	0	12
13	14	Program Transportation	Beds	2,493	25	0	0	92	0	13
14	15	Other	Beds	2,493	25	0	0	92	0	14
15	17	Administrative	Beds	2,493	25	0	0	92	0	15
16	18	Directors Fees	Beds	2,493	25	0	0	92	0	16
17	19	Professional Services	Beds	2,493	25	412,869	0	92	15,236	17
18	20	Fees, Subscription, Promotions	Beds	2,493	25	23,945	0	92	884	18
19	21	Clerical & General Office Expense	Beds	2,493	25	10,377,428	9,978,005	92	382,962	19
20	22	Employee Benefits & Payroll Tax	Beds	2,493	25	1,045,059	0	92	38,566	20
21	23	Inservice Training & Education	Beds	2,493	25	32,865	0	92	1,213	21
22	24	Travel and Seminar	Beds	2,493	25	129,776	0	92	4,789	22
23	25	Other Admin. Staff Transportatio	Beds	2,493	25	0	0	92	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,493	25	1,731,253	0	92	63,889	24
25	TOTALS					\$ 15,193,470	\$ 10,226,789		\$ 560,690	25

Facility Name & ID Number Heritage Health Dwight

0050492 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 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,493	25	\$	92	\$	1
2	30	Depreciation	Beds	2,493	25	584,981	92	21,588	2
3	31	Amortization of Pre-Op & Org	Beds	2,493	25		92		3
4	32	Interest	Beds	2,493	25	65,658	92	2,423	4
5	33	Real Estate Taxes	Beds	2,493	25		92		5
6	34	Rent-Facility & Grounds	Beds	2,493	25	180,106	92	6,647	6
7	35	Rent-Equipment & Vehicles	Beds	2,493	25	318,843	92	11,766	7
8	36	Other	Beds	2,493	25		92		8
9	38	Medically Nec Transportation	Beds	2,493	25		92		9
10	39	Ancillary Service Centers	Beds	2,493	25	4,685	92	173	10
11	40	Barber and Beauty Shops	Beds	2,493	25		92		11
12	41	Coffee and Gift Shops	Beds	2,493	25		92		12
13	42	Other	Beds	2,493	25		92		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	\$	\$ 42,597	25

Facility Name & ID Number

Heritage Health Dwight

0050492

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4																				
5																				
Working Capital																				
6	Busey Bank	xx	Working Capital						45,780	6										
7										7										
8										8										
9	TOTAL Facility Related								45,780	9										
B. Non-Facility Related*																				
10	Interest Income								(5,970)	10										
11										11										
12	Allocated Corporate								2,423	12										
13										13										
14	TOTAL Non-Facility Related								(3,547)	14										
15	TOTALS (line 9+line14)								42,233	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.)

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.		\$	58,865	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.)		\$	56,751	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,114)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	59,588	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.		\$	57,474	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	47,166	8
	2016	45,690	9
	2017	48,116	10
	2018	56,062	11
	2019	56,751	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

Accrual = 1.05 * Current Year Payment

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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 Dwight COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0050492

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)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>050504483019</u>	_____	\$ <u>56,750.74</u>	\$ <u>56,751.00</u>
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u><u>56,750.74</u></u>	\$ <u><u>56,751.00</u></u>

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,300 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization. [xx]

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization. [xx]

(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 NO [xx]

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:

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for row numbers. Row 1: Land, Row 2: (blank), Row 3: TOTALS

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	92		1972	\$ 1,006,686	\$		\$	\$	4
5				323,779					5
6									6
7									7
8									8
Improvement Type**									
9	1992 Improvements		1992	8,456					9
10	1993 Improvements		1993	586,243					10
11	1994 Improvements		1994	12,874					11
12	1995 Improvements		1995	496					12
13	1996 Improvements		1996	7,350					13
14	1997 Improvements		1997	119,787					14
15	1998 Improvements		1998	19,959					15
16	1999 Improvements		1999	9,926					16
17	2000 Improvements		2000	2,830					17
18	2001 Improvements		2001	14,572					18
19	2002 Improvements		2002	47,984					19
20	2003 Improvements		2003	11,616					20
21	2004 Improvements		2004	21,939					21
22	2005 Improvements		2005	29,372					22
23	2006 Improvements		2006	113,123					23
24	2007 Improvements		2007	77,078					24
25	2008 Improvements		2008	28,139					25
26	2009 Improvements		2009	310,836					26
27	2010 Improvements		2010	936,394					27
28	2011 Improvements		2011	133,396					28
29	2012 Improvements		2012	22,690					29
30	2013 Improvements		2013	15,027					30
31									31
32									32
33									33
34	C/O Allocation				21,588		21,588		34
35	Book Depreciation				144,966		144,966		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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
37		\$	\$		\$	\$	\$
38	<u>2014 Improvements</u>	<u>2014</u>	<u>125,457</u>				
39							
40	<u>Rooftop unit replacement - add Lennox; remove Trane</u>	<u>2015</u>	<u>12,936</u>				
41	<u>Install amp disconnect to generator</u>	<u>2015</u>	<u>2,870</u>				
42	<u>Replacment of condensor in mult zone compressor unit</u>	<u>2015</u>	<u>6,310</u>				
43							
44	<u>Upgrade of HVAC controls</u>	<u>2015</u>	<u>24,430</u>				
45							
46	<u>Replaced Carrier Unit compressor</u>	<u>2016</u>	<u>6,523</u>				
47							
48	<u>Replaced original boiler</u>	<u>2017</u>	<u>180,571</u>				
49	<u>Replaced condensor coil</u>	<u>2017</u>	<u>14,036</u>				
50	<u>Added emergency power to critical panel</u>	<u>2017</u>	<u>4,626</u>				
51							
52	<u>Infrastructure rewiring - IT related</u>	<u>2018</u>	<u>3,406</u>				
53	<u>Replace gas water heater</u>	<u>2018</u>	<u>17,173</u>				
54	<u>Replace air conditioner - laundry room</u>	<u>2018</u>	<u>6,525</u>				
55	<u>Install outlets - emergency hallway</u>	<u>2018</u>	<u>7,503</u>				
56	<u>Sewer re-piping</u>	<u>2018</u>	<u>16,880</u>				
57							
58	<u>Replace roof compressor</u>	<u>2019</u>	<u>9,135</u>				
59	<u>Replace water line and mixing valve - Mechanical Room</u>	<u>2019</u>	<u>3,821</u>				
60	<u>Shower room floor remediation -removal and disposition of ceramic tiles; installed new flooring</u>	<u>2019</u>	<u>18,173</u>				
61							
62							
63	<u>No Improvements in 2020</u>	<u>2020</u>					
64							
65							
66							
67							
68							
69							
70	TOTAL (lines 4 thru 69)		\$ 4,320,927	\$ 166,554		\$ 166,554	\$

**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	\$ 962,551	\$ 16,858	\$ 16,858	\$		\$	71
72	Current Year Purchases	7,520						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 970,071	\$ 16,858	\$ 16,858	\$		\$	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		2009 Turtletop bus	2008	\$ 61,091	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 61,091	\$	\$	\$		\$	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)	\$ 5,352,089	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 183,412	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 183,412	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 Dwight

0050492

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: Dwight Continental Manor.

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:		92		\$ 220,500			3
4	Additions							4
5								5
6								6
7	TOTAL		92		\$ 220,500			7

10. Effective dates of current rental agreement:

Beginning 4/1/2009

Ending 3/31/2029

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

Fiscal Year Ending Annual Rent

12.	<u>12/2021</u>	\$ <u>220,500</u>
13.	<u>12/2022</u>	\$ <u>220,500</u>
14.	<u>12/2023</u>	\$ <u>220,500</u>

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 45,917 Description: Office equipment & 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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 216,581	\$		\$ 216,581	1
2	Licensed Speech and Language Development Therapist		hrs			35,712			35,712	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			246,794	1,474		248,268	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				256,086		256,086	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____					11,468			11,468	13
14	TOTAL			\$		\$ 510,555	\$ 257,560		\$ 768,115	14

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2020**

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,328	\$	1
2	Cash-Patient Deposits	11,332		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	117,300		3
4	Supply Inventory (priced at <u>FIFO</u>)	24,899		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,848		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,665,038)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (1,508,331)	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	3,052,140		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,041,603		16
17	Accumulated Depreciation (book methods)	(3,215,404)		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)	\$ 878,339	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (629,992)	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,332		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	188,734		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,404		31
32	Accrued Real Estate Taxes(Sch.IX-B)	59,588		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Bed Tax</u>	10,531		36
37	<u>Deferred Stimulus</u>	250,759		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 532,348	\$	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)	\$ 532,348	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,162,340)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (629,992)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,553,657)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,553,657)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	391,317	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)	\$ 391,317	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)	\$ (1,162,340)	24 *

* This must agree with page 17, line 47.

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

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

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,918,937	1
2	Discounts and Allowances for all Levels	(1,707,813)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,211,124	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,393,900	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,393,900	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	421,338	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,588	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	469,432	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	11,045	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 903,403	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5,970	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,970	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)	\$ 6,514,397	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,087,094	31
32	Health Care	2,538,121	32
33	General Administration	1,466,104	33
B. Capital Expense			
34	Ownership	531,495	34
C. Ancillary Expense			
35	Special Cost Centers	500,266	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)*	\$ 6,123,080	40
41	Income before Income Taxes (line 30 minus line 40)**	391,317	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 391,317	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 Dwight

0050492

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	2,014	2,098	\$ 71,971	\$ 34.30	1
2	Assistant Director of Nursing	1,730	1,802	54,552	30.27	2
3	Registered Nurses	15,110	15,739	504,917	32.08	3
4	Licensed Practical Nurses	8,697	9,059	239,761	26.47	4
5	CNAs & Orderlies	52,981	55,188	885,700	16.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,579	2,687	81,386	30.29	8
9	Activity Director					9
10	Activity Assistants	7,057	7,352	87,212	11.86	10
11	Social Service Workers	1,870	1,948	41,489	21.30	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,435	23,369	283,871	12.15	15
16	Dishwashers					16
17	Maintenance Workers	4,844	5,046	96,828	19.19	17
18	Housekeepers	8,429	8,781	86,502	9.85	18
19	Laundry	5,644	5,879	58,026	9.87	19
20	Administrator	1,894	1,973	88,083	44.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,810	11,261	271,023	24.07	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)	146,094	152,182	\$ 2,851,321 *	\$ 18.74	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	\$ 6,640	L1 C3	35
36	Medical Director	10,800	L9 C3	36
37	Medical Records Consultant	963	L10 C3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	5,530	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	2,907	L12 C3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 26,840		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 0		50
51	Licensed Practical Nurses	0		51
52	Certified Nurse Assistants/Aides	69,290	L10 C3	52
53	TOTAL (lines 50 - 52)	\$ 69,290		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Rita Quigley	Administrator		\$ 88,083	Workers' Compensation Insurance	\$ 29,571	IDPH License Fee	\$	
				Unemployment Compensation Insurance	8,711	Advertising: Employee Recruitment	3,510	
				FICA Taxes	218,126	Health Care Worker Background Check (Indicate # of checks performed _____)	2,217	
				Employee Health Insurance	122,897	Patient Background Checks		
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*		PR	8,989	
						Dues & Subscriptions	7,951	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 88,083	Other Benefits	63,708	License & Fees	1,095	
(List each licensed administrator separately.)				Central Office Allocation	38,566	Central Office Allocation	884	
						Less: Public Relations Expense	(8,989)	
						Non-allowable advertising	(4,731)	
						Yellow page advertising	()	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 481,579	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,926	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
								2,042
								65
							Seminar Expense	610
								2,282
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 4,999
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
Heritage Operations Group	Management		\$ 320,929					
Legal adj to Zero			4,090					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 325,019					
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Health Dwight

0050492

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 - \$6,440
- (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. \$ 182,579
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. \$ 219
- (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 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.

Heritage Manor - Dwight
 IDPH ID# 0050492
 HFS Cost Report - December 31, 2020
 Schedule V - Column 5 Reclassifications

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

<u>Line Item</u>	
Purchased Drugs and Medications	\$ 256,086
Purchased Hospital Services	0
Purchased Laboratory Services	6,375
Purchased Radiology Services	5,093
Amount Reclassified to Line 39	\$ <u>267,554</u>

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

<u>Line Item</u>	
Provider Participation Fee - \$1.50	\$ (50,508)
Provider Assesment Fee - \$6.07	(132,071)
	\$ <u>(182,579)</u>
Provider Participation Fee	\$ <u>182,579</u>

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

<u>Line Item</u>	
Pharmacy Consultant Fees	\$ <u>5,530</u>