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.

I. IDPH License ID Number: 0048132

Facility Name: Heritage Health Elgin

Address: 355 Raymond Street (Number) Elgin (City) 60120 (Zip Code)

County: Kane

Telephone Number: (847) 697-6636 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: July 2006

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: David M Underwood **Telephone Number:** (309)8237135
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) David M Underwood
(Title) EVP & CFO

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	94	Skilled (SNF)	94	34,404	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	94	TOTALS	94	34,404	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,061	2,564	4,206	23,831	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,061	2,564	4,206	23,831	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.27%

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 2006

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

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified 94 and days of care provided 4,206

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 Elgin # 0048132 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	335,638	19,695	5,848	361,181		361,181	4,586	365,767			1
2	Food Purchase		193,502		193,502		193,502	(16)	193,486			2
3	Housekeeping	151,999	45,026		197,025		197,025	6,114	203,139			3
4	Laundry	35,941	14,860		50,801		50,801	437	51,238			4
5	Heat and Other Utilities			158,975	158,975		158,975	1,456	160,431			5
6	Maintenance	148,570	73,696	111,608	333,874		333,874	17,844	351,718			6
7	Other (specify):*											7
8	TOTAL General Services	672,148	346,779	276,431	1,295,358		1,295,358	30,421	1,325,779			8
	B. Health Care and Programs											
9	Medical Director			22,000	22,000		22,000		22,000			9
10	Nursing and Medical Records	2,433,794	131,333	19,094	2,584,221	(5,691)	2,578,530	8,740	2,587,270			10
10a	Therapy		142,645	22,406	165,051	(158,627)	6,424		6,424			10a
11	Activities	93,559	4,166		97,725		97,725	5	97,730			11
12	Social Services	46,037		3,300	49,337		49,337	131	49,468			12
13	CNA Training	2,393			2,393		2,393		2,393			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,575,783	278,144	66,800	2,920,727	(164,318)	2,756,409	8,876	2,765,285			16
	C. General Administration											
17	Administrative	98,981			98,981		98,981		98,981			17
18	Directors Fees											18
19	Professional Services			378,927	378,927		378,927	(359,818)	19,109			19
20	Dues, Fees, Subscriptions & Promotions			206,114	206,114	(184,345)	21,769	(8,915)	12,854			20
21	Clerical & General Office Expenses	354,679	28,612	10,375	393,666		393,666	391,287	784,953			21
22	Employee Benefits & Payroll Taxes			585,558	585,558		585,558	39,405	624,963			22
23	Inservice Training & Education			2,187	2,187		2,187	1,167	3,354			23
24	Travel and Seminar			15,455	15,455		15,455	(10,456)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			51,296	51,296		51,296	65,278	116,574			26
27	Other (specify):*			125,717	125,717		125,717	(125,717)				27
28	TOTAL General Administration	453,660	28,612	1,375,629	1,857,901	(184,345)	1,673,556	(7,769)	1,665,787			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,701,591	653,535	1,718,860	6,073,986	(348,663)	5,725,323	31,528	5,756,851			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 Elgin #0048132 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							128,903	128,903			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			45,670	45,670		45,670	19,504	65,174			32
33	Real Estate Taxes							52,491	52,491			33
34	Rent-Facility & Grounds			411,720	411,720		411,720	(404,929)	6,791			34
35	Rent-Equipment & Vehicles			31,546	31,546		31,546	12,022	43,568			35
36	Other (specify):*											36
37	**TOTAL Ownership**			488,936	488,936		488,936	(192,009)	296,927			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			746,061	746,061	164,318	910,379	115,932	1,026,311			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					184,345	184,345		184,345			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			746,061	746,061	348,663	1,094,724	115,932	1,210,656			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,701,591	653,535	2,953,857	7,308,983		7,308,983	(44,549)	7,264,434			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 Elgin # 0048132 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	(1,221)			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	(4,203)			17
18	Fines and Penalties				18
19	Entertainment	(15,349)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,864)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(125,717)			24
25	Fund Raising, Advertising and Promotional	(5,615)			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)**	$ (154,969)		$	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)	110,420		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 110,420		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (44,549)		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 Elgin

ID# 0048132

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		(2,864)	19	11
12		(1,221)	32	12
13		(125,717)	27	13
14		(5,615)	20	14
15		(4,203)	20	15
16		0	27	16
17		(15,349)	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**	(154,969)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	4,586	0	0	0	0	0	0	0	0	4,586	1
2	Food Purchase	0	0	(16)	0	0	0	0	0	0	0	0	(16)	2
3	Housekeeping	0	0	6,114	0	0	0	0	0	0	0	0	6,114	3
4	Laundry	0	0	437	0	0	0	0	0	0	0	0	437	4
5	Heat and Other Utilities	0	0	1,456	0	0	0	0	0	0	0	0	1,456	5
6	Maintenance	0	0	17,844	0	0	0	0	0	0	0	0	17,844	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	30,421	0	0	0	0	0	0	0	0	30,421	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	(15,010)	23,750	0	0	0	0	0	0	0	0	8,740	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	131	0	0	0	0	0	0	0	0	131	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	(15,010)	23,886	0	0	0	0	0	0	0	0	8,876	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	(2,864)	(372,521)	15,567	0	0	0	0	0	0	0	0	(359,818)	19
20	Fees, Subscriptions & Promotions	(9,818)	0	903	0	0	0	0	0	0	0	0	(8,915)	20
21	Clerical & General Office Expenses	0	0	391,287	0	0	0	0	0	0	0	0	391,287	21
22	Employee Benefits & Payroll Taxes	0	0	39,405	0	0	0	0	0	0	0	0	39,405	22
23	Inservice Training & Education	0	(72)	1,239	0	0	0	0	0	0	0	0	1,167	23
24	Travel and Seminar	(15,349)	0	4,893	0	0	0	0	0	0	0	0	(10,456)	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	65,278	0	0	0	0	0	0	0	0	65,278	26
27	Other (specify):*	(125,717)	0	0	0	0	0	0	0	0	0	0	(125,717)	27
28	**TOTAL General Administration**	(153,748)	(372,593)	518,572	0	0	0	0	0	0	0	0	(7,769)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(153,748)	(387,603)	572,879	0	0	0	0	0	0	0	0	31,528	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Elgin **#** 0048132 **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 D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	106,846	0	22,057	0	0	0	0	0	0	0	128,903	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,221)	18,249	0	2,476	0	0	0	0	0	0	0	19,504	32
33	Real Estate Taxes	0	52,491	0	0	0	0	0	0	0	0	0	52,491	33
34	Rent-Facility & Grounds	0	(411,720)	0	6,791	0	0	0	0	0	0	0	(404,929)	34
35	Rent-Equipment & Vehicles	0	0	0	12,022	0	0	0	0	0	0	0	12,022	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,221)	(234,134)	0	43,346	0	0	0	0	0	0	0	(192,009)	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	115,755	0	177	0	0	0	0	0	0	0	115,932	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	115,755	0	177	0	0	0	0	0	0	0	115,932	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(154,969)	(505,982)	572,879	43,523	0	0	0	0	0	0	0	(44,549)	45

Facility Name & ID Number Heritage Health Elgin # 0048132 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		$ (15,010)	$ (15,010)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy		(72)	(72)	2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy		115,755	115,755	3
4	V	19	Adjustment for Related Organization	372,521	Heritage Operations Group, LLC			(372,521)	4
5	V								5
6	V	34	Adjustment for Related Organization	411,720	Heritage Manor Real Estate, LLC			(411,720)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		52,491	52,491	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		17,213	17,213	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		106,846	106,846	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		1,036	1,036	10
11	V								11
12	V								12
13	V								13
14	Total			$ 784,241			$ 278,259	$ * (505,982)	14

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

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [xx] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Heritage Operations Group		$ 4,586	$ 4,586	15
16	V	2	Food Purchase		Heritage Operations Group		(16)	(16)	16
17	V	3	Housekeeping		Heritage Operations Group		6,114	6,114	17
18	V	4	Laundry		Heritage Operations Group		437	437	18
19	V	5	Heat & Other Utilities		Heritage Operations Group		1,456	1,456	19
20	V	6	Maintenance		Heritage Operations Group		17,844	17,844	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		23,750	23,750	23
24	V	11	Activities		Heritage Operations Group		5	5	24
25	V	12	Social Service		Heritage Operations Group		131	131	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		15,567	15,567	31
32	V	20	Fees, Subscription, Promotions		Heritage Operations Group		903	903	32
33	V	21	Clerical & General Office Expenses		Heritage Operations Group		391,287	391,287	33
34	V	22	Employee Benefits & Payroll Taxes		Heritage Operations Group		39,405	39,405	34
35	V	23	Inservice Training & Education		Heritage Operations Group		1,239	1,239	35
36	V	24	Travel and Seminar		Heritage Operations Group		4,893	4,893	36
37	V	25	Other Admin. Staff Transportation		Heritage Operations Group		0		37
38	V	26	Insurance-Prop.Liab.Malpract		Heritage Operations Group		65,278	65,278	38
39	Total			$			$ 572,879	$ * 572,879	39

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

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [xx] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	27		$	Heritage Operations Group		$ 0	$	15
16	V	30			Heritage Operations Group		22,057	22,057	16
17	V	31			Heritage Operations Group		0		17
18	V	32			Heritage Operations Group		2,476	2,476	18
19	V	33			Heritage Operations Group		0		19
20	V	34			Heritage Operations Group		6,791	6,791	20
21	V	35			Heritage Operations Group		12,022	12,022	21
22	V	36			Heritage Operations Group		0		22
23	V	38			Heritage Operations Group		0		23
24	V	39			Heritage Operations Group		177	177	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			$			$ 43,523	$ * 43,523	39

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

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	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 Elgin # 0048132 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES xx NO

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,493	25	$ 121,634	$ 121,338	94	$ 4,586	1
2	2	Food Purchase	Beds	2,493	25	(423)	0	94	(16)	2
3	3	Housekeeping	Beds	2,493	25	162,156	0	94	6,114	3
4	4	Laundry	Beds	2,493	25	11,591	0	94	437	4
5	5	Heat & Other Utilities	Beds	2,493	25	38,605	0	94	1,456	5
6	6	Maintenance	Beds	2,493	25	473,233	88,567	94	17,844	6
7	7	Other	Beds	2,493	25	0	0	94	0	7
8	9	Medical Director	Beds	2,493	25	0	0	94	0	8
9	10	Nursing & Medical Records	Beds	2,493	25	629,872	35,401	94	23,750	9
10	11	Activities	Beds	2,493	25	129	0	94	5	10
11	12	Social Service	Beds	2,493	25	3,478	3,478	94	131	11
12	13	Nurse Aide Training	Beds	2,493	25	0	0	94	0	12
13	14	Program Transportation	Beds	2,493	25	0	0	94	0	13
14	15	Other	Beds	2,493	25	0	0	94	0	14
15	17	Administrative	Beds	2,493	25	0	0	94	0	15
16	18	Directors Fees	Beds	2,493	25	0	0	94	0	16
17	19	Professional Services	Beds	2,493	25	412,869	0	94	15,567	17
18	20	Fees, Subscription, Promotions	Beds	2,493	25	23,945	0	94	903	18
19	21	Clerical & General Office Expens	Beds	2,493	25	10,377,428	9,978,005	94	391,287	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,493	25	1,045,059	0	94	39,405	20
21	23	Inservice Training & Education	Beds	2,493	25	32,865	0	94	1,239	21
22	24	Travel and Seminar	Beds	2,493	25	129,776	0	94	4,893	22
23	25	Other Admin. Staff Transportatio	Beds	2,493	25	0	0	94	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,493	25	1,731,253	0	94	65,278	24
25	TOTALS					$ 15,193,470	$ 10,226,789		$ 572,879	25

Facility Name & ID Number Heritage Health Elgin # 0048132 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	$	$	94	$	1
2	30	Depreciation	Beds	2,493	25	584,981		94	22,057	2
3	31	Amortization of Pre-Op & Org	Beds	2,493	25			94		3
4	32	Interest	Beds	2,493	25	65,658		94	2,476	4
5	33	Real Estate Taxes	Beds	2,493	25			94		5
6	34	Rent-Facility & Grounds	Beds	2,493	25	180,106		94	6,791	6
7	35	Rent-Equipment & Vehicles	Beds	2,493	25	318,843		94	12,022	7
8	36	Other	Beds	2,493	25			94		8
9	38	Medically Nec Transportation	Beds	2,493	25			94		9
10	39	Ancillary Service Centers	Beds	2,493	25	4,685		94	177	10
11	40	Barber and Beauty Shops	Beds	2,493	25			94		11
12	41	Coffee and Gift Shops	Beds	2,493	25			94		12
13	42	Other	Beds	2,493	25			94		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	$		$ 43,523	25

Facility Name & ID Number Heritage Health Elgin # 0048132 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	Busey Bank		xx	Mortgage			$	$			$ 17,213	1
2	Busey Bank		xx	Loan Fee Amortization							1,036	2
3												3
4												4
5												5
	Working Capital											
6	Busey Bank		xx	Working Capital							45,670	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 63,919	9
	B. Non-Facility Related*											
10	Interest Income										(1,221)	10
11												11
12	Allocated Corporate										2,476	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,255	14
15	TOTALS (line 9+line14)						$	$			$ 65,174	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 Elgin # 0048132 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 52,491	2
3. Under or (over) accrual (line 2 minus line 1).		$ 52,491	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.		$ 52,491	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	56,158	8
	2016	56,349	9
	2017	54,767	10
	2018	52,345	11
	2019	52,491	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 Elgin COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0048132

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.	0624201002		$ 1,378.26	$ 1,378.00
2.	0624201003		$ 50,068.04	$ 50,068.00
3.	0624201004		$ 1,045.02	$ 1,045.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 52,491.32	$ 52,491.00

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 Elgin # 0048132 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,275 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).

None

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1989	$ 80,000	1
2					2
3	TOTALS			$ 80,000	3

Facility Name & ID Number Heritage Health Elgin # 0048132 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	94			1989	$ 720,000	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1989 Improvements			1989	180,739						9
10	1990 Improvements			1990	662,666						10
11	1991 Improvements			1991	52,989						11
12	1992 Improvements			1992	6,777						12
13	1993 Improvements			1993	54,564						13
14	1994 Improvements			1994	81,347						14
15	1995 Improvements			1995	146,394						15
16	1996 Improvements			1996	23,749						16
17	1997 Improvements			1997	6,338						17
18	1998 Improvements			1998	6,485						18
19	1999 Improvements			1999	8,891						19
20	2000 Improvements			2000	17,615						20
21	2001 Improvements			2001	65,619						21
22	2002 Improvements			2002	180,648						22
23	2003 Improvements			2003	109,549						23
24	2004 Improvements			2004							24
25	2005 Improvements			2005	5,776						25
26	2006 Improvements			2006	11,336						26
27	2007 Improvements			2007	152,101						27
28	2008 Improvements			2008	33,200						28
29	2009 Improvements			2009	29,086						29
30	2010 Improvements			2010	6,607						30
31	2011 Improvements			2011	14,250						31
32	2012 Improvements			2012	18,330						32
33											33
34	C/O Allocation					22,057		22,057			34
35	Book Depreciation					96,901		96,901			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 Elgin # 0048132 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	2013 Improvements	2013	359,103						38
39	2014 Improvements	2014							39
40									40
41	Replace secondary water heater	2016	12,166						41
42	Repalce flooring - North day room	2016	7,026						42
43	Bathroom remodeling - Units 6A, 6B and 29 - remove tubs and	2016	19,779						43
44	replace with showers; added new tile and wall boards								44
45									45
46	Replaced main water heater	2017	18,744						46
47	Installed new nurse call system	2017	48,861						47
48									48
49	Retilled shower room	2018	5,158						49
50	Acquired and installed security door - memory care	2018	19,111						50
51	Replaced fan coil and heat pumps on (2) HVAC units	2018	23,500						51
52									52
53	Purchase and install walk-in combination cooler-freezer	2019	39,054						53
54									54
55	Replaced laundry room air conditioner	2020	8,730						55
56	Replaced doors - South Wing & Garage	2020	8,449						56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,164,737	$ 118,958		$ 118,958	$	$	70

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

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,080,514	$ 9,945	$ 9,945	$		$	71
72	Current Year Purchases	16,855						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,097,369	$ 9,945	$ 9,945	$		$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,342,106	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 128,903	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 128,903	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 Elgin # 0048132 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: None

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ 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: $ 31,546 Description: Televisions, Mattresses, 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 Elgin # 0048132 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				
3	Classroom Wages (a)				
4	Clinical Wages (b)		2,393		2,393
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 2,393	$	$ 2,393
10	SUM OF line 9, col. 1 and 2 (e)	$ 2,393			

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	$		$ 357,919	$		$ 357,919	1
2	Licensed Speech and Language Development Therapist		hrs			28,515			28,515	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			359,627	733		360,360	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				141,912		141,912	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					22,406			22,406	13
14	TOTAL			$		$ 768,467	$ 142,645		$ 911,112	14

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

STATE OF ILLINOIS

Facility Name & ID Number Heritage Health Elgin # 0048132 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	$ 800	$	1
2	Cash-Patient Deposits	40,925		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	548,710		3
4	Supply Inventory (priced at FIFO)	18,500		4
5	Short-Term Investments			5
6	Prepaid Insurance	562		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	711,732		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,321,229	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,321,229	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	40,925		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	377,101		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,396		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	10,064		36
37	Deferred Stimulus	269,745		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 699,231	$	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)**	$ 699,231	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 621,998	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,321,229	$	48

*(See instructions.)

Facility Name & ID Number Heritage Health Elgin # 0048132 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**	$ 220,888	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 220,888	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	401,110	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)**	$ 401,110	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)**	$ 621,998	24 *

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

Facility Name & ID Number Heritage Health Elgin # 0048132 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	$ 6,879,373	1
2	Discounts and Allowances for all Levels	(1,696,032)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,183,341	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,879,309	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,879,309	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	412,115	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	234,101	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	6	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 646,222	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,221	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,221	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)**	$ 7,710,093	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,295,358	31
32	Health Care	2,920,727	32
33	General Administration	1,857,901	33
	B. Capital Expense		
34	Ownership	488,936	34
	C. Ancillary Expense		
35	Special Cost Centers	746,061	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)***	$ 7,308,983	40
41	**Income before Income Taxes (line 30 minus line 40)****	401,110	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 401,110	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 Elgin # 0048132 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,082	2,169	$ 106,838	$ 49.26	1
2	Assistant Director of Nursing	4,074	4,244	188,136	44.33	2
3	Registered Nurses	16,701	17,397	694,100	39.90	3
4	Licensed Practical Nurses	6,295	6,557	221,266	33.75	4
5	CNAs & Orderlies	52,278	54,456	1,048,377	19.25	5
6	CNA Trainees	241	251	2,393	9.53	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,664	7,983	175,077	21.93	8
9	Activity Director					9
10	Activity Assistants	6,363	6,628	93,559	14.12	10
11	Social Service Workers	1,901	1,980	46,037	23.25	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,021	20,855	335,638	16.09	15
16	Dishwashers					16
17	Maintenance Workers	6,506	6,777	148,570	21.92	17
18	Housekeepers	11,104	11,566	151,999	13.14	18
19	Laundry	1,830	1,907	35,941	18.85	19
20	Administrator	2,066	2,152	98,981	45.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,903	12,399	354,679	28.61	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)	151,029	157,321	$ 3,701,591 *	$ 23.53	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 5,848	L1 C3	35
36	Medical Director		22,000	L9 C3	36
37	Medical Records Consultant		236	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,691	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		3,300	L12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 37,075		49

C. CONTRACT NURSES

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

Facility Name & ID Number Heritage Health Elgin # 0048132 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Greg Lagtapon	Administrator		$ 98,981
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 98,981

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	$ 376,063
Legal adj to Zero		2,864
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 378,927

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 37,932
Unemployment Compensation Insurance	7,862
FICA Taxes	283,172
Employee Health Insurance	200,637
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	55,955
Central Office Allocation	39,405
TOTAL (agree to Schedule V, line 22, col.8)	$ 624,963

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,565
Health Care Worker Background Check	
(Indicate # of checks performed)	621
Patient Background Checks	
PR	4,429
Dues & Subscriptions	7,494
License & Fees	5,474
Central Office Allocation	903
Less: Public Relations Expense	(4,429)
Non-allowable advertising	(4,203)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,854

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	9,219
	78
Seminar Expense	6,158
	(10,456)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,999

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Health Elgin # 0048132 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 - $6,578**

(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. $ **184,345**
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. $ **0**

(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	800							
1010			CASH IN BANK								
1040			CASH IN BANK-PAYROLL								
1100			ACCOUNTS RECEIVABLE	548,710							
1110			MEDICARE RECEIVABLES								
1125			IPA INCOME RECEIVABLE								
1130			MEDICARE COST REPORT								
1132			US HHS STIMULUS SETTLEMEI	-269,745							
1140			UNAPPLIED CASH RECEIPTS								
1145			A/R SUSPENSE-REFUNDS								
1190			ACCRUED INTEREST REC								
1200			PREPAID INSURANCE	562							
1220			OTHER PREPAID EXPENSES								
1300			FOOD INVENTORY	18,500							
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	40,925							
1550			LOAN FEES	0							
1560			REAL ESTATE TAX ESCROW								
1575			REIMBURSABLE PURCHASES								
1850			INTRACOMPANY	711,732							
2010			ACCOUNTS PAYABLE	0							
2095			BONUSES PAYABLE								
2100			ACCRUED PAYROLL	-132,515							
2110			ACCRUED VACATION PAY	-244,586							
2120			UC TAXES PAYABLE								
2125			FICA TAX PAYABLE	-1,396	-1,396						
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 PAYABLI	0							
2310			SALES TAX PAYABLE								
2320			IPA PAYMENTS PAYABLE	-10,064							
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	-40,925							
2600			MORTGAGE PAYABLE	0							
2650			EQUIPMENT LOAN PAYABLE								
2695			CURRENT PORTION LT DEBT								
2696			DEFERRED INCOME TAXES								
2710			COMMON STOCK								
2720			RETAINED EARNINGS	-220,888							
2970			PROFIT/LOSS FOR PERIOD	-401,110							
3007.1			PATIENT DAYS-PRIVATE	2,564							
3007.2			PATIENT DAYS-IPA	17,061							
3007.3			PATIENT DAYS-MEDICARE	4,206							
3007.4			PATIENT DAYS-CONVERSION								
3007.5			PATIENT DAYS-LICENSED								
3007.6			PATIENT DAYS-TOTAL								
3010		1	BASIC CHARGE-PRIVATE & VA	-6,865,811		0	0	0	0		
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0		
3020		1	BASIC CHARGE-IPA	0		0	0	0	0		
3030		1	BASIC CHARGE-MEDICARE	0		0	0	0	0		
3035		4	DAY CARE/HOME CARE			0	0	0	0		
3040		1	LIGHT NURSING CARE	0		0	0	0	0		
3050		1	MEDIUM NURSING CARE			0	0	0	0		
3060		1	HEAVY NURSING CARE			0	0	0	0		
3061		1	SKILLED NURSING CARE								
3080		1	NURSING SUPPLIES-PRIVATE	-12,489		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	-234,101		0	0	0	0		
3101		17	DRUGS-OTHER								
3110		6	PT-PRIVATE	-1,879,309		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	132,739							
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	1,696,032		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	-412,115		42	3	0	0		
3520		16	RENT INCOME	0		6	0	6	0		
3530		13	BEAUTY SHOP	0		0	0	0	0		
3560		12	ACTIVITY FUND INCOME	0		0	0	0	0		
3570		12	VENDING INCOME/EXPENSE	0		0	0	0	0		
3580		12	MANAGEMENT FEES			0	0	0	0		
3590		1	EQUIPMENT RENTAL	-1,073		0	0	0	0		
3595		21	RESIDENT TRANSPORTATION	0		0	0	0	0		
3600		21	MISC INCOME	-6		0	0	0	0		
4110			GENERAL & ADMINIST WAGES	324,124	354,679	21	1	17	0		
4111			ADMINISTRATOR WAGES	98,981	98,981	17	1	0	0		
4115			VACATION & SICK - G&A	30,555		21	1	0	0		
4120	4475		EMPLOYEE BENEFITS	50,408	585,558	22	3	0	0		
4125			EMPLOYEE HEPETITIS VACCIN	0		22	3	0	0		
4130			EMPLOYEE SCHOLARSHIP WA	2,554	132,739	21	1	0	0		
4135			EMPLOYEE SCHOLARSHIP CC	2,993		23	3	0	0		
4220			DIRECTORS FEES	0	0	18	3	0	0		
4250	4255		OFFICE SUPPLIES	28,612	28,612	21	2	0	0		
4260			TELEPHONE	10,375	10,375	21	3	0	0		
4275			TRAINING & EMPLOYEE DEVL	2,187	2,187	23	3	16	0	**	
4280			GENERAL TRAVEL	9,219	15,455	24	3	16	0		
4281			MEAL EXPENSE FOR TRAVEL	78		24	3	19	0		
4285			EDUCATION & SEMINAR	6,158		24	3	19	-15,349	***	
4290			HELP WANTED ADVERTISING	2,565	73,375	20	3	0	0		-51,606
4291			PROMOTIONAL ADVERTISING	1,186		20	3	25	-1,186		
4292			PUBLIC RELATIONS	4,429		20	3	25	-4,429		
4300			LICENSES & FEES	57,080		20	3	17	0		
4310			DUES & SUBSCRIPTIONS	7,494		20	3	17	-4,203		
4320			CONTRIBUTIONS	0		27	3	20	0		
4350			PROFESSIONAL FEES	6,406	378,927	19	3	22	-2,864		
4355			MEDICAL DIRECTOR	22,000	22,000	9	3	0	0		
4360			UTILIZATION REVIEW	0		10	3	0	0		
4361			OTHER PHYSICIAN FEES			39	3	0	0		
4362			MEDICAL RECORDS CONSULT	236		10	3	0	0		
4363			PHARMACIST FEES	5,691		10	3	0	0		
4364			SOC SERV/ACT CONSULT	3,300	3,300	12	3	0	0		
4370			TV RENTAL	2,686		35	3	5	0		
4380			INCOME TAXES		125,717	27	3	26	0		
4383			BACKGROUND CHECKS	621		20	3	26	0		
4400			PAYROLL TAXES	291,034		22	3	0	0		
4401			PAYROLL TAXES ADMINIST	0		22	3	0	0		
4410			GROUP INSURANCE	200,637		22	3	0	0		
4420			LIABILITY INSURANCE	51,296	51,296	26	3	0	0		
4425			INSURANCE-OWNERS			22	3	21	0		
4430			WORKMENS COMP INSURANC	37,932		22	3	0	0		
4450			CENTRAL OFFICE FEES	372,521		19	3	34	0	**	
4460			BAD DEBTS	125,717		27	3	24	-125,717		
4470			LOST ITEMS-RESIDENTS	0		27	3	0			
4490			MISCELLANEOUS	0		27	3	0	0		
4510			REAL ESTATE TAXES	0	0	33	3	0	0		
4600			LEASED EQUIPMENT	28,860	31,546	35	3	16	0		
5110			MAINTENANCE SALARIES	139,210	148,570	6	1	0	0		
5120			MAINTENANCE SICK & VAC	9,360		6	1	0	0		
5130			ELECTRIC	90,455	158,975	5	3	0	0		
5131			NATURAL GAS	3,818		5	3	0	0		
5132			HEATING & DEISEL OIL			5	3	0	0		
5133			WATER & SEWER	64,702		5	3	0	0		
5134			TRASH COLLECTION	10,545	111,608	6	3	0	0		
5140			PROPERTY PLANT REPLACEM	12,780	73,696	6	2	0	0		
5160			GENERAL REPAIR & MAINT	60,916		6	2	0	0		
5165			MAINTENANCE CONTRACTS	101,063		6	3	0	0		
5210			DIETARY WAGES	313,162	335,638	1	1	0	0		
5220			DIETARY SICK & VAC	22,476		1	1	0	0		
5240			DIETARY CONSULTANT	5,848	5,848	2	3	13	0		
5248			FOOD PURCHASES	193,502	193,502	2	2	0	0		
5250			SUPPLIES-DISHWASHING	4,230	19,695	1	2	0	0		
5260			DIETARY REPLACEMENT	1,406		1	2	0	0		
5270			KITCHEN SUPPLIES-PAPER	14,059		1	2	0	0		
5295			MEAL CREDIT	0		2	2	0	0		
5310			LAUNDRY WAGES	31,773	35,941	4	1	0	0		
5340			LAUNDRY SICK & VAC	4,168		4	1	0	0		
5370			LAUNDRY REPLACEMENT	8,884	14,860	4	2	0	0		
5380			LAUNDRY REIMBURSEMENT			4	3	0	0		
5390			LAUNDRY SUPPLIES	5,976		4	2	0	0		
5410			HOUSEKEEPING WAGES	143,013	151,999	3	1	0	0		
5440			HOUSEKEEPING SICK & VAC	8,986		3	1	0	0		
5480			HOUSEKEEPING SUPPLIES	44,251	45,026	3	2	0	0		
5490			HOUSEKEEPING SUPPLIES-PF	775		3	2	0	0		
6010			RN WAGES-MEDICARE		2,433,794	10	1	0	0		
6020			RN WAGES-NON MEDICARE	626,619		10	1	0	0		
6030			DON WAGES	106,838		10	1	0	0		
6035			ADON	188,136		10	1	0	0		
6040			RN SICK & VACATION	67,481		10	1	0	0		
6110			LPN WAGES-MEDICARE	206,210		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	15,056		10	1	0	0		
6210			AIDE WAGES-MEDICARE			10	1	0	0		
6220			AIDE WAGES-NON MEDICARE	966,098		10	1	0	0		
6230			WARD CLERKS			10	1	0	0		
6240			AIDE VACATION & SICK	82,279		10	1	0	0		
6245			CONTRACT NURSES-RN	0		10	3	0	0		
6246			CONTRACT NURSES-LPN	0		10	3	0	0		
6247			CONTRACT NURSES-AIDES	0		10	3	0	0		
6250			NURSE AIDE TRAINING WAGES	2,393	2,393	13	1	0	0		
6255			NURSE AID TRAINING EXP	0	0	13	2	0	0		
6260			NURSE AIDE TRAINING REIMB	0		0	0	0	0		
6270			REHAB WAGES	171,637		10	1	0	0		
6275			REHAB SICK & VAC	3,440		10	1	0	0		
6280			NURSING DEPT EDUCATION			23	3	0	0		
6290			NURSING SUPPLIES	14,585	131,333	10	2	0	0		
6295			NURSING SUPPLIES	112,625		10	2	0	0		
6390			REPLACEMENT-NURSING	4,123		10	2	0	0		
6490			NURSING OTHER	13,167	19,094	10	3	0	0		
7280			DRUG PURCHASES	141,912	142,645	39	2	0	0	***	
7281			DRUG PURCHASES-OTHER	0		39	2				
7380			LABORATORY SERVICES	22,406	22,406	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	89,214	93,559	11	1	0	0		
7540			ACTIVITIES SICK & VAC	4,345		11	1	0	0		
7590			ACTIVITIES SUPPLIES	4,166	4,166	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	359,627	746,061	39	3	0	0	***	
7660			PT SUPPLIES	733		39	2	0	0		
7710			SOCIAL SERVICE WAGES	42,007	46,037	12	1	0	0		
7720			SOCIAL SERVICE SICK & VAC	4,030		12	1	0	0		
7730			SOCIAL SERVICE EXPENSES	0	0	12	2	0	0		
7740			OT FEE	357,919		39	3	0	0	***	
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0		
7770			SPEECH THERAPY FEE	28,515		39	3	0	0	***	
7800			BEAUTICIAN WAGES		0	40	1	0	0		
7810			BEAUTICIAN SICK & VAC			40	1	0	0		
7820			BEAUTICIAN FEES	0	0	40	3	0	0		
7890			BEAUTY SHOP SUPPLIES	0	0	40	2	0	0		
7910			VOLUNTEER COORDINATOR			21	1	0	0		
7940			VOL COORD SICK & VAC			21	1	0	0		
7960			VOL COORD SUPPLIES	0		21	2	0	0		
8100			RENT	411,720	411,720	34	3	0	0		
8120			INTEREST EXPENSE	45,670	45,670	32	3	14	-1,221		
8130			DEPRECIATION	0	0	30	3	9	0		
8150			LOAN FEE AMORTIZATION	0		32	3	0	0		0
9510			INTEREST INCOME	-1,221		32	0	10	0		
9520			MISC NON-OPERATING INCOM	0		0	0	0	0		
9700			INCOME TAXES	0		0	0	0	0		
				7,175,023	7,308,983						
					133,960						
GRAND TOTALS				-401,110					-154,969		
				(NET INCOME)							
				0							
			FACILITY NAME:								
			FACILITY ID:	0							
			FACILITY UNITS:	162							
			BALANCE SHEET TOTAL	0							

1,009	1,009 CASH	800
1,100	1,100 ACCTS RE	781,844
1,101	1,101 ALLOW. F	(233,134)
1,110	1,110 ACCTS RECEIV-M/C	
1,125	1,125 ACCTS RECEIV-IPA	
1,132	1,132 US HHS S	(269,745)
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	562
1,300	1,300 DIETARY I	18,500
1,310	1,310 SUPPLIES INVENTORY	
1,320	1,320 LINEN INVENTORY	
1,409	1,409 LAND	0
1,450	1,450 FURNITUF	0
1,460		0
1,475	1,475 BUILDING	0
1,490	1,490 ACCUM DI	0
1,530	1,530 RESIDENT	40,925
1,550	1,550 LOAN FEE	0
1,551	1,551 LOAN FEES ADDED	
1,850	1,850 INTERCOI	711,732
2,010	2,010 ACCOUNT	0
2,100	2,095 BONUSES PAYABLE	
2,100	2,100 ACCRUEL	(132,515)
2,100	2,100 PR CLEARING-BENEFITS	
2,100	2,100 PR CLEARING-LABOR	
2,110	2,110 ACCRUEL	(244,586)
2,120	2,120 U.C. TAXE	0
2,125	2,125 FICA TAXE	(1,396)
2,130	2,130 FEDERAL W/H TAX PAYABLE	
2,140	2,140 STATE W/H TAX PAYABLE	
2,152	2,152 WORKERS COMP ACCRUAL	
2,225	2,225 EMPLOYEEE INSURANCE REFUND	
2,230	2,230 PAYROLL SAVINGS	
2,235	2,240 UNITED FUND	
2,240	2,246 GROUP INSURANCE - CAFETERIA	
2,246	2,250 401K W/H	
2,250		
2,260	2,260 WAGE GA	0
2,300	2,300 ACCRUEL	0
2,320	2,320 IPA PAYMI	(10,064)
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	(40,925)
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 RETAINED	(220,888)
	net income	(401,110)
	balance	0

3,007	3,007 PATIENT D	2,564
3,007	3,007 PATIENT D	17,061
3,007	3,007 PATIENT D	4,206
3,007		0
3,007		
3,007		
3,007		
3,010	3,010 BASIC CH	(6,865,811)
3,020	3,020 BASIC CH	0
3,030	3,030 BASIC CH	0
3,040	ASSESSM	132,739
3,050		0
3,060		0
3,061		0
3,080	3,080 NURSING	(12,489)
3,081	3,081 NURSING	0
3,082	3,082 NURSING	0
3,083	3,083 NURSING	0
3,100	3,100 DRUGS-M	(234,101)
3,101		0
3,110	3,110 PHYSICAL	(1,879,309)
3,111		0
3,112	3,112 PHYSICAL	0
3,113	3,113 PHYSICAL	0
3,140	3,140 LABORATORY INCOME	
3,150		0
3,151		
3,152	3,152 ST/OT TH	0
3,153	3,153 ST/OT TH	0
3,160	3,185 REHAB/ISOLATION/OTHER CHG	
3,410	3,410 IPA/OTHE	0
3,411	3,411 MEDICARI	0
3,420	3,420 MEDICARI	1,472,886
3,452	3,452 HHS STIM	(412,115)
3,520	3,520 RENT INC	0
3,530	3,530 BEAUTY S	0
3,560		0
3,570	3,570 VENDING	0
3,590	3,590 EQUIPMEI	(1,073)
3,595	3,595 RESIDENT	0
3,600	3,600 MISC INCO	(6)
4,110	4,110 G&A WAG	324,124
4,111	4,111 ADMINISTI	98,981
4,115	4,115 G&A PTO	30,555
4,120	4,120 EMPLOYE	50,560
4,121		0
4,130	4,130 EMPLOYE	2,554
4,135	4,135 EMPLOYE	2,993
4,250	4,250 OFFICE S	10,245
4,255	4,255 POSTAGE	1,600
4,260	4,260 TELEPHO	10,375
4,275	4,275 TRAINING	2,187
4,276		0
4,280	4,280 GENERAL	9,219
4,281	4,281 MEAL EXF	78
4,285	4,285 EDUCATIC	6,158
4,289	4,289 MEETINGS	0
4,290	4,290 HELP WAI	2,565
4,291	4,291 PROMOTI	1,186
4,292	4,292 PUBLIC R	4,429
4,300	4,300 LICENSE	57,080
4,310	4,310 DUES & S	7,494
4,320	4,320 CONTRIBI	0
4,350	4,350 PROFESS	6,406
4,355	4,355 MEDICAL	22,000
4,362		236
4,363		5,691
4,364	4,364 SOCIAL S	3,300
4,370	4,370 TV RENTA	2,686
4,383	4,383 BACKGRO	621
4,390	4,390 OTHER TA	0
4,400	4,400 PAYROLL	291,034
4,401	4,401 PAYROLL	0
4,410	4,410 GROUP IN	200,637
4,420	4,420 LIABILITY	51,296
4,430	4,430 WORKMA	37,096
4,435	4,435 W/C-FIRS	0
4,436	4,436 DRUG TES	836
4,450	4,450 MANAGEM	372,521
4,460	4,460 BAD DEBT	125,717
4,461	4,461 BAD DEBT	223,146
4,470	4,470 LOST ITEI	0
4,475	4,475 UNIFORM	(152)
4,486	4,486 SERVICE	68,116
4,490	4,490 MISC EXP	81
4,496	4,496 MISC. M.I.S	16,767
4,510	4,510 REAL EST	0
4,600	4,600 LEASED E	28,860
5,110	5,110 MAINTENA	139,210
5,120	5,120 MAINTENA	9,360
5,130	5,130 ELECTRIC	90,455
5,131	5,131 NATURAL	3,818
5,133	5,133 WATER &	64,702
5,134	5,134 TRASH CO	10,545
5,140	5,140 PROP/PLA	12,780
5,160	5,160 GENERAL	60,916
5,165	5,165 MAINTENA	32,947
5,210	5,210 DIETARY	313,162
5,220	5,220 DIETARY	22,476
5,248	5,248 FOOD PU	193,421
5,250	5,250 SUPPLIES	4,230
5,260	5,260 REPLACE	1,406
5,270	5,270 KITCHEN	14,059
5,295	5,295 MEAL INC	0
5,310	5,310 LAUNDRY	31,773
5,340	5,340 LAUNDRY	4,168
5,370	5,370 REPLACE	8,884
5,230	5,230 DIETARY	5,848
5,390	5,390 LAUNDRY	5,976
5,410	5,410 HOUSEKE	143,013
5,440	5,440 HOUSEKE	8,986
5,480	5,480 SUPPLIES	44,251
5,490	5,490 SUPPLIES	775
6,020	6,020 RN WAGE	626,619
6,030	6,030 DON WAG	106,838
6,035	6,035 ADON WA	188,136
6,040	6,040 RN PTO &	67,481
6,120	6,120 LPN WAG	206,210
6,140	6,140 LPN PTO	15,056
6,220	6,220 AIDES WA	966,098
6,240	6,240 AIDES PT	82,279
6,245	RN CONT	0
6,246	LPN CONT	0
6,247	AIDES CO	0
6,250		2,393
6,255		0
6,260		0
6,270	6,270 REHAB W	171,637
6,275	6,275 REHAB PT	3,440
6,290	6,290 NURSING	14,585
6,295	6,295 NURSING	112,625
6,390	6,390 REPLACE	4,123
6,490	6,490 OTHER	13,167
7,280	7,280 DRUG PU	141,912
7,281	7,281 DRUG PU	0
7,380	7,380 LABORAT	10,698
7,391	7,390 X-RAY SE	11,708
7,393		0
7,510	7,510 ACTIVITIE	89,214
7,540	7,540 ACTIVITIE	4,345
7,590	7,590 ACTIVITIE	4,166
7,620	7,620 PHYSICAL	359,627
7,660	7,660 P.T. SUPF	733
7,710	7,710 SOCIAL S	42,007
7,720	7,720 SOCIAL S	4,030
7,730	7,730 SOCIAL S	0
7,740	7,740 OCCUPAT	357,919
7,750		
7,770	7,770 SPEECH T	28,515
7,820	7,820 BEAUTICIA	0
7,890		0
7,960		0
8,120	8,120 INTEREST	0
8,125		45,670
8,130	8,130 DEPRECIA	0
8,150		0
9,510	9,510 INTEREST	(1,221)
9,520	9,520 MISC NON	0
9,530	4,220	0
	8,100	411,720
	9,702	0
	5,230	0
		(401,110)

Expenses Fixed Assets

0

Heritage Manor - Elgin
IDPH ID# 48132
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	$	141,912
Purchased Hospital Services		10,845
Purchased Laboratory Services		10,698
Purchased Radiology Services		863
Amount Reclassified to Line 39	$	164,318

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

Line Item		
Provider Participation Fee - $1.50	$	(51,606)
Provider Assesment Fee - $6.07		(132,739)
	$	(184,345)
Provider Participation Fee	$	184,345

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

Line Item		
Pharmacy Consultant Fees	$	5,691