		FOR BHF USE					

LL1

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: 0048116

Facility Name: Heritage Health Gibson City

Address: 620 E 1st Street (Number) Gibson City (City) 60936 (Zip Code)

County: Ford

Telephone Number: (217) 784-4257 **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 Gibson City # 0048116 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	60	Skilled (SNF)	60	21,960	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	60	TOTALS	60	21,960	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	11,686	4,735	1,289	17,710	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,686	4,735	1,289	17,710	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.65%

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 [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified 60 and days of care provided 1,289

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 Gibson City # 0048116 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	239,454	22,887	4,583	266,924		266,924	2,927	269,851			1
2	Food Purchase		144,071		144,071		144,071	(10)	144,061			2
3	Housekeeping	64,182	22,129		86,311		86,311	3,903	90,214			3
4	Laundry	49,410	11,619		61,029		61,029	279	61,308			4
5	Heat and Other Utilities			46,866	46,866		46,866	929	47,795			5
6	Maintenance	66,079	47,481	77,739	191,299		191,299	11,389	202,688			6
7	Other (specify):*											7
8	**TOTAL General Services**	419,125	248,187	129,188	796,500		796,500	19,417	815,917			8
	B. Health Care and Programs											
9	Medical Director			12,061	12,061		12,061		12,061			9
10	Nursing and Medical Records	1,414,666	154,970	341,669	1,911,305	(3,836)	1,907,469	(2,733)	1,904,736			10
10a	Therapy		93,643	4,339	97,982	(94,146)	3,836		3,836			10a
11	Activities	59,769	1,458		61,227		61,227	3	61,230			11
12	Social Services	38,715		3,120	41,835		41,835	84	41,919			12
13	CNA Training	2,031	2,868		4,899		4,899		4,899			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,515,181	252,939	361,189	2,129,309	(97,982)	2,031,327	(2,646)	2,028,681			16
	C. General Administration											
17	Administrative	92,239			92,239		92,239		92,239			17
18	Directors Fees											18
19	Professional Services			216,339	216,339		216,339	(204,106)	12,233			19
20	Dues, Fees, Subscriptions & Promotions			159,510	159,510	(136,531)	22,979	(11,877)	11,102			20
21	Clerical & General Office Expenses	191,625	27,669	7,951	227,245		227,245	249,758	477,003			21
22	Employee Benefits & Payroll Taxes			431,027	431,027		431,027	25,152	456,179			22
23	Inservice Training & Education			860	860		860	791	1,651			23
24	Travel and Seminar			498	498		498	3,123	3,621			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			34,979	34,979		34,979	41,667	76,646			26
27	Other (specify):*			35,288	35,288		35,288	(35,288)				27
28	**TOTAL General Administration**	283,864	27,669	886,452	1,197,985	(136,531)	1,061,454	69,220	1,130,674			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,218,170	528,795	1,376,829	4,123,794	(234,513)	3,889,281	85,991	3,975,272			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 Gibson City #0048116 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							134,335	134,335			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			36,440	36,440		36,440	18,490	54,930			32
33	Real Estate Taxes							36,159	36,159			33
34	Rent-Facility & Grounds			329,100	329,100		329,100	(324,165)	4,935			34
35	Rent-Equipment & Vehicles			42,079	42,079		42,079	7,674	49,753			35
36	Other (specify):*											36
37	TOTAL Ownership			407,619	407,619		407,619	(127,507)	280,112			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			487,629	487,629	97,982	585,611	228,267	813,878			39
40	Barber and Beauty Shops		51	814	865		865		865			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					136,531	136,531		136,531			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		51	488,443	488,494	234,513	723,007	228,267	951,274			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,218,170	528,846	2,272,891	5,019,907		5,019,907	186,751	5,206,658			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 Gibson City # 0048116 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	(2,366)			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	(3,334)			17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(35,288)			24
25	Fund Raising, Advertising and Promotional	(9,119)			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)**	$ (50,107)		$	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)	236,858		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 236,858		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 186,751		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 Gibson City

ID# 0048116

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		0	19	11
12		(2,366)	32	12
13		(35,288)	27	13
14		(9,119)	20	14
15		(3,334)	20	15
16		0	27	16
17		0	34	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	(50,107)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Gibson City # 0048116 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	2,927	0	0	0	0	0	0	0	0	2,927	1
2	Food Purchase	0	0	(10)	0	0	0	0	0	0	0	0	(10)	2
3	Housekeeping	0	0	3,903	0	0	0	0	0	0	0	0	3,903	3
4	Laundry	0	0	279	0	0	0	0	0	0	0	0	279	4
5	Heat and Other Utilities	0	0	929	0	0	0	0	0	0	0	0	929	5
6	Maintenance	0	0	11,389	0	0	0	0	0	0	0	0	11,389	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	19,417	0	0	0	0	0	0	0	0	19,417	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	(17,892)	15,159	0	0	0	0	0	0	0	0	(2,733)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	3	0	0	0	0	0	0	0	0	3	11
12	Social Services	0	0	84	0	0	0	0	0	0	0	0	84	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	(17,892)	15,246	0	0	0	0	0	0	0	0	(2,646)	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	0	(214,043)	9,937	0	0	0	0	0	0	0	0	(204,106)	19
20	Fees, Subscriptions & Promotions	(12,453)	0	576	0	0	0	0	0	0	0	0	(11,877)	20
21	Clerical & General Office Expenses	0	0	249,758	0	0	0	0	0	0	0	0	249,758	21
22	Employee Benefits & Payroll Taxes	0	0	25,152	0	0	0	0	0	0	0	0	25,152	22
23	Inservice Training & Education	0	0	791	0	0	0	0	0	0	0	0	791	23
24	Travel and Seminar	0	0	3,123	0	0	0	0	0	0	0	0	3,123	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	41,667	0	0	0	0	0	0	0	0	41,667	26
27	Other (specify):*	(35,288)	0	0	0	0	0	0	0	0	0	0	(35,288)	27
28	**TOTAL General Administration**	(47,741)	(214,043)	331,004	0	0	0	0	0	0	0	0	69,220	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(47,741)	(231,935)	365,667	0	0	0	0	0	0	0	0	85,991	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Gibson City # 0048116 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	120,256	0	14,079	0	0	0	0	0	0	0	134,335	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,366)	19,276	0	1,580	0	0	0	0	0	0	0	18,490	32
33	Real Estate Taxes	0	36,159	0	0	0	0	0	0	0	0	0	36,159	33
34	Rent-Facility & Grounds	0	(328,500)	0	4,335	0	0	0	0	0	0	0	(324,165)	34
35	Rent-Equipment & Vehicles	0	0	0	7,674	0	0	0	0	0	0	0	7,674	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,366)	(152,809)	0	27,668	0	0	0	0	0	0	0	(127,507)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	228,154	0	113	0	0	0	0	0	0	0	228,267	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	228,154	0	113	0	0	0	0	0	0	0	228,267	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(50,107)	(156,590)	365,667	27,781	0	0	0	0	0	0	0	186,751	45

Facility Name & ID Number Heritage Health Gibson City # 0048116 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
Main 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		$ (17,892)	$ (17,892)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy				2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy		228,154	228,154	3
4	V	19	Adjustment for Related Organization	214,043	Heritage Operations Group, LLC			(214,043)	4
5	V								5
6	V	34	Adjustment for Related Organization	328,500	Heritage Manor Real Estate, LLC			(328,500)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		36,159	36,159	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		18,195	18,195	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		120,256	120,256	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		1,081	1,081	10
11	V								11
12	V								12
13	V								13
14	Total			$ 542,543			$ 385,953	$ * (156,590)	14

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

Facility Name & ID Number Heritage Health Gibson City # 0048116 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		$ 2,927	$ 2,927	15
16	V	2	Food Purchase		Heritage Operations Group		(10)	(10)	16
17	V	3	Housekeeping		Heritage Operations Group		3,903	3,903	17
18	V	4	Laundry		Heritage Operations Group		279	279	18
19	V	5	Heat & Other Utilities		Heritage Operations Group		929	929	19
20	V	6	Maintenance		Heritage Operations Group		11,389	11,389	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		15,159	15,159	23
24	V	11	Activities		Heritage Operations Group		3	3	24
25	V	12	Social Service		Heritage Operations Group		84	84	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		9,937	9,937	31
32	V	20	Fees, Subscription, Promotions		Heritage Operations Group		576	576	32
33	V	21	Clerical & General Office Expenses		Heritage Operations Group		249,758	249,758	33
34	V	22	Employee Benefits & Payroll Taxes		Heritage Operations Group		25,152	25,152	34
35	V	23	Inservice Training & Education		Heritage Operations Group		791	791	35
36	V	24	Travel and Seminar		Heritage Operations Group		3,123	3,123	36
37	V	25	Other Admin. Staff Transportation		Heritage Operations Group		0		37
38	V	26	Insurance-Prop.Liab.Malpract		Heritage Operations Group		41,667	41,667	38
39	Total			$			$ 365,667	$ * 365,667	39

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

Facility Name & ID Number Heritage Health Gibson City # 0048116 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		14,079	14,079	16
17	V	31			Heritage Operations Group		0		17
18	V	32			Heritage Operations Group		1,580	1,580	18
19	V	33			Heritage Operations Group		0		19
20	V	34			Heritage Operations Group		4,335	4,335	20
21	V	35			Heritage Operations Group		7,674	7,674	21
22	V	36			Heritage Operations Group		0		22
23	V	38			Heritage Operations Group		0		23
24	V	39			Heritage Operations Group		113	113	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			$			$ 27,781	$ * 27,781	39

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

Facility Name & ID Number Heritage Health Gibson City # 0048116 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	Main 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 Gibson City # 0048116 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	60	$ 2,927	1
2	2	Food Purchase	Beds	2,493	25	(423)	0	60	(10)	2
3	3	Housekeeping	Beds	2,493	25	162,156	0	60	3,903	3
4	4	Laundry	Beds	2,493	25	11,591	0	60	279	4
5	5	Heat & Other Utilities	Beds	2,493	25	38,605	0	60	929	5
6	6	Maintenance	Beds	2,493	25	473,233	88,567	60	11,389	6
7	7	Other	Beds	2,493	25	0	0	60	0	7
8	9	Medical Director	Beds	2,493	25	0	0	60	0	8
9	10	Nursing & Medical Records	Beds	2,493	25	629,872	35,401	60	15,159	9
10	11	Activities	Beds	2,493	25	129	0	60	3	10
11	12	Social Service	Beds	2,493	25	3,478	3,478	60	84	11
12	13	Nurse Aide Training	Beds	2,493	25	0	0	60	0	12
13	14	Program Transportation	Beds	2,493	25	0	0	60	0	13
14	15	Other	Beds	2,493	25	0	0	60	0	14
15	17	Administrative	Beds	2,493	25	0	0	60	0	15
16	18	Directors Fees	Beds	2,493	25	0	0	60	0	16
17	19	Professional Services	Beds	2,493	25	412,869	0	60	9,937	17
18	20	Fees, Subscription, Promotions	Beds	2,493	25	23,945	0	60	576	18
19	21	Clerical & General Office Expens	Beds	2,493	25	10,377,428	9,978,005	60	249,758	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,493	25	1,045,059	0	60	25,152	20
21	23	Inservice Training & Education	Beds	2,493	25	32,865	0	60	791	21
22	24	Travel and Seminar	Beds	2,493	25	129,776	0	60	3,123	22
23	25	Other Admin. Staff Transportatio	Beds	2,493	25	0	0	60	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,493	25	1,731,253	0	60	41,667	24
25	TOTALS					$ 15,193,470	$ 10,226,789		$ 365,667	25

Facility Name & ID Number Heritage Health Gibson City # 0048116 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	$	$	60	$	1
2	30	Depreciation	Beds	2,493	25	584,981		60	14,079	2
3	31	Amortization of Pre-Op & Org	Beds	2,493	25			60		3
4	32	Interest	Beds	2,493	25	65,658		60	1,580	4
5	33	Real Estate Taxes	Beds	2,493	25			60		5
6	34	Rent-Facility & Grounds	Beds	2,493	25	180,106		60	4,335	6
7	35	Rent-Equipment & Vehicles	Beds	2,493	25	318,843		60	7,674	7
8	36	Other	Beds	2,493	25			60		8
9	38	Medically Nec Transportation	Beds	2,493	25			60		9
10	39	Ancillary Service Centers	Beds	2,493	25	4,685		60	113	10
11	40	Barber and Beauty Shops	Beds	2,493	25			60		11
12	41	Coffee and Gift Shops	Beds	2,493	25			60		12
13	42	Other	Beds	2,493	25			60		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	$		$ 27,781	25

Facility Name & ID Number Heritage Health Gibson City # 0048116 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			$	$			$ 18,195	1
2	Busey Bank		xx	Loan Fee Amortization							1,081	2
3												3
4												4
5												5
	Working Capital											
6	Busey Bank		xx	Working Capital							36,440	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 55,716	9
	B. Non-Facility Related*											
10	Interest Income										(2,366)	10
11												11
12	Allocated Corporate										1,580	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (786)	14
15	TOTALS (line 9+line14)						$	$			$ 54,930	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 Gibson City # 0048116 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.)	$	36,159	2
3. Under or (over) accrual (line 2 minus line 1).	$	36,159	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.	$	36,159	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2015	35,492	8
2016	35,864	9
2017	35,864	10
2018	35,550	11
2019	36,159	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 Gibson City COUNTY Ford

FACILITY IDPH LICENSE NUMBER 0048116

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.	09-11-11-482-001		$ 36,009.58	$ 36,009.58
2.	09-11-11-479-017		$ 149.80	$ 149.80
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 36,159.38	$ 36,159.00

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 Gibson City # 0048116 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,300 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			1979	$ 20,000	1
2					2
3	TOTALS			$ 20,000	3

Facility Name & ID Number Heritage Health Gibson City # 0048116 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	60			1962	$ 815,350	$		$	$	$	4
5				1992	912,769						5
6											6
7											7
8											8
	Improvement Type**										
9	1981 Improvements			1981	41,753						9
10	1982 Improvements			1982	6,437						10
11	1983 Improvements			1983	240						11
12	1984 Improvements			1984	873						12
13	1985 Improvements			1985	6,526						13
14	1986 Improvements			1986	20,979						14
15	1987 Improvements			1987	2,222						15
16	1988 Improvements			1988	2,452						16
17	1989 Improvements			1989	28,639						17
18	1990 Improvements			1990	99,326						18
19	1991 Improvements			1991	36,637						19
20	1993 Improvements			1993	40,838						20
21	1994 Improvements			1994	66,399						21
22	1995 Improvements			1995	1,060						22
23	1996 Improvements			1996	34,470						23
24	1998 Improvements			1998	12,299						24
25	1999 Improvements			1999	12,197						25
26	2000 Improvements			2000	1,295						26
27	2001 Improvements			2001	6,100						27
28	2002 Improvements			2002	31,496						28
29											29
30											30
31											31
32											32
33											33
34	C/O Allocation					14,079		14,079			34
35	Book Depreciation					97,116		97,116			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 Gibson City # 0048116 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	2003 Improvements	2003	$ 35,701	$		$	$	$	37
38	2004 Improvements	2004	37,123						38
39	2005 Improvements	2005	19,233						39
40	2006 Improvements	2006	56,750						40
41	2007 Improvements	2007	18,188						41
42	2008 Improvements	2008	51,595						42
43	2009 Improvements	2009	42,933						43
44	2010 Improvements	2010	47,346						44
45	2011 Improvements	2011	33,488						45
46	2012 Improvements	2012	9,668						46
47	2013 Improvements	2013	12,896						47
48	2014 Improvements	2014	100,056						48
49									49
50	Installed water heater	2015	4,228						50
51	Replace generator control board	2015	3,385						51
52	Remodeled front entrance and lobby areas - new flooring,	2015	46,794						52
53	painting, cabinets and gables								53
54									54
55	Add new circuit panel	2016	3,160						55
56	Install hot water storage tank	2016	4,200						56
57									57
58	Installed water heater-laundry	2017	6,600						58
59	Replaced dry valve	2017	4,387						59
60	Replaced dry pendant	2017	18,847						60
61	Replaced softener resin	2017	3,800						61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,740,735	$ 111,195		$ 111,195	$	$	70

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

Facility Name & ID Number Heritage Health Gibson City # 0048116 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,740,735	$ 111,195		$ 111,195	$	$	1
2									2
3	Remodeled both east and west corridors with new paint,	2017	191,638						3
4	handrails, artwork and signage; installed new light fixtures and								4
5	painted all walls in the therapy gym and the RESTORE resident								5
6	rooms; remodeled bathrooms in same RESTORE and therapy rooms								6
7	with new drywall and reworked shower tile and drain slope								7
8									8
9	No 2018 Improvements								9
10									10
11	Replace front door	2019	4,331						11
12	Replace exterior sidewalks	2019	13,000						12
13	Repave main parking lot	2019	42,765						13
14									14
15	Install new water heater	2020	4,070						15
16	Fire sprinkler system conversion and piping replacement	2020	39,528						16
17	Purchase and install new 100 gallon water heater	2020	6,975						17
18	Replace compressor in the Walk-In Freezer	2020	2,697						18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,045,739	$ 111,195		$ 111,195	$	$	34

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

Facility Name & ID Number Heritage Health Gibson City # 0048116 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	$ 633,421	$ 16,920	$ 16,920	$		$	71
72	Current Year Purchases	40,350						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 673,771	$ 16,920	$ 16,920	$		$	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		2017 Dodge Grand Caravan	2016	$ 43,540	$ 6,220	$ 6,220	$		$	76
77										77
78										78
79										79
80	TOTALS			$ 43,540	$ 6,220	$ 6,220	$		$	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)	$ 3,783,050	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 134,335	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 134,335	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 Gibson City # 0048116 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: $ 42,079 Description: Mattresses, beds, copiers and televisions
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Heritage Health Gibson City # 0048116 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			2,868		2,868
3	Classroom Wages	(a)				
4	Clinical Wages	(b)		2,031		2,031
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$	$ 4,899	$	$ 4,899
10	SUM OF line 9, col. 1 and 2	(e)	$ 4,899			

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	$		$ 225,754	$		$ 225,754	1
2	Licensed Speech and Language Development Therapist		hrs			32,766			32,766	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			229,109	0		229,109	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				93,643		93,643	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					4,339			4,339	13
14	TOTAL			$		$ 491,968	$ 93,643		$ 585,611	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 Gibson City # 0048116 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	$ 936	$	1
2	Cash-Patient Deposits	9,393		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	125,330		3
4	Supply Inventory (priced at FIFO)	11,673		4
5	Short-Term Investments			5
6	Prepaid Insurance	2,696		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(5,397,373)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (5,247,345)	$	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)**	$ (5,247,345)	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,393		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	142,229		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,915		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Bed Tax	8,377		36
37	Deferred Stimulus	160,713		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 329,627	$	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)**	$ 329,627	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,576,972)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (5,247,345)	$	48

*(See instructions.)

Facility Name & ID Number Heritage Health Gibson City # 0048116 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**	$ (4,979,171)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,979,171)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(597,801)	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)**	$ (597,801)	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)**	$ (5,576,972)	24 *

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

Facility Name & ID Number Heritage Health Gibson City # 0048116 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	$ 3,701,639	1
2	Discounts and Allowances for all Levels	(1,233,387)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,468,252	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,506,120	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,506,120	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	291,234	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	753	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	147,569	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(3)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 439,553	23
	D. Non-Operating Revenue		
24	Contributions	5,760	24
25	Interest and Other Investment Income***	2,366	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,126	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund	55	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 55	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,422,106	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	796,500	31
32	Health Care	2,129,309	32
33	General Administration	1,197,985	33
	B. Capital Expense		
34	Ownership	407,619	34
	C. Ancillary Expense		
35	Special Cost Centers	488,494	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)***	$ 5,019,907	40
41	**Income before Income Taxes (line 30 minus line 40)****	(597,801)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (597,801)	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 Gibson City # 0048116 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	2,064	2,150	$ 78,793	$ 36.65	1
2	Assistant Director of Nursing			688		2
3	Registered Nurses	7,223	7,524	273,970	36.41	3
4	Licensed Practical Nurses	8,913	9,284	284,359	30.63	4
5	CNAs & Orderlies	45,848	47,759	776,856	16.27	5
6	CNA Trainees	204	213	2,031	9.54	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,355	3,494	59,769	17.11	10
11	Social Service Workers	1,845	1,922	38,715	20.14	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,398	20,206	239,454	11.85	15
16	Dishwashers					16
17	Maintenance Workers	3,875	4,036	66,079	16.37	17
18	Housekeepers	6,068	6,321	64,182	10.15	18
19	Laundry	2,963	3,086	49,410	16.01	19
20	Administrator	2,014	2,098	92,239	43.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,827	7,112	191,625	26.94	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)	110,597	115,205	$ 2,218,170 *	$ 19.25	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		$ 4,583	L1 C3	35
36	Medical Director		12,061	L9 C3	36
37	Medical Records Consultant		720	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,836	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		3,120	L12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 24,320		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 162,628	L10 C3	50
51	Licensed Practical Nurses		91,172	L10 C3	51
52	Certified Nurse Assistants/Aides		83,313	L10 C3	52
53	TOTAL (lines 50 - 52)		$ 337,113		53

Facility Name & ID Number Heritage Health Gibson City # 0048116 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Amanda Gronsky	Administrator		$ 92,239
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 92,239

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	$ 216,339
Legal adj to Zero		0
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 216,339

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,319
Unemployment Compensation Insurance	3,737
FICA Taxes	169,690
Employee Health Insurance	151,667
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	75,614
Central Office Allocation	25,152
TOTAL (agree to Schedule V, line 22, col.8)	$ 456,179

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	2,904
Health Care Worker Background Check	
(Indicate # of checks performed)	914
Patient Background Checks	
PR	2,601
Dues & Subscriptions	5,434
License & Fees	4,608
Central Office Allocation	576
Less: Public Relations Expense	(2,601)
Non-allowable advertising	(3,334)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,102

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	498
	0
Seminar Expense	0
	3,123
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,621

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Health Gibson City # 0048116 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 - $4,200**

(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. $ **136,531**
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. $ **670**

(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	936						
1010			CASH IN BANK							
1040			CASH IN BANK-PAYROLL							
1100			ACCOUNTS RECEIVABLE	125,330						
1110			MEDICARE RECEIVABLES							
1125			IPA INCOME RECEIVABLE							
1130			MEDICARE COST REPORT							
1132			US HHS STIMULUS SETTLEME	-160,713						
1140			UNAPPLIED CASH RECEIPTS							
1145			A/R SUSPENSE-REFUNDS							
1190			ACCRUED INTEREST REC							
1200			PREPAID INSURANCE	2,696						
1220			OTHER PREPAID EXPENSES							
1300			FOOD INVENTORY	11,673						
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	9,393						
1550			LOAN FEES	0						
1560			REAL ESTATE TAX ESCROW							
1575			REIMBURSABLE PURCHASES							
1850			INTRACOMPANY	-5,397,373						
2010			ACCOUNTS PAYABLE	0						
2095			BONUSES PAYABLE							
2100			ACCRUED PAYROLL	-27,182						
2110			ACCRUED VACATION PAY	-115,047						
2120			UC TAXES PAYABLE							
2125			FICA TAX PAYABLE	-8,915	-8,915					
2130			FIT PAYABLE							
2140			STATE W/H PAYABLE		0					
2145			EARNED INCOME CREDIT							
2150			UC FED CREDIT REDUCTION							
2230			PAYROLL SAVINGS							
2235			IRA W/HOLDINGS							
2240			UNITED WAY							
2245			GROUP INSURANCE PAYABLE							
2246			GROUP INSURANCE PAYABLE-CAFETERIA							
2260			WAGE GARNISHMENTS							
2280			MISC PAYROLL DEDUCTIONS							
2300			ACCRUED INTEREST PAYABL	0						
2310			SALES TAX PAYABLE							
2320			IPA PAYMENTS PAYABLE	-8,377						
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	-9,393						
2600			MORTGAGE PAYABLE	0						
2650			EQUIPMENT LOAN PAYABLE							
2695			CURRENT PORTION LT DEBT							
2696			DEFERRED INCOME TAXES							
2710			COMMON STOCK							
2720			RETAINED EARNINGS	4,979,171						
2970			PROFIT/LOSS FOR PERIOD	597,801						
3007.1			PATIENT DAYS-PRIVATE	4,735						
3007.2			PATIENT DAYS-IPA	11,686						
3007.3			PATIENT DAYS-MEDICARE	1,289						
3007.4			PATIENT DAYS-CONVERSION							
3007.5			PATIENT DAYS-LICENSED							
3007.6			PATIENT DAYS-TOTAL							
3010		1	BASIC CHARGE-PRIVATE & VA	-3,693,570		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	-7,991		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	-147,569		0	0	0	0	
3101		17	DRUGS-OTHER							
3110		6	PT-PRIVATE	-1,506,120		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	103,591						
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	1,233,387		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	-291,234		42	3	0	0	
3520		16	RENT INCOME	0		6	0	6	0	
3530		13	BEAUTY SHOP	-753		0	0	0	0	
3560		12	ACTIVITY FUND INCOME	-55		0	0	0	0	
3570		12	VENDING INCOME/EXPENSE	0		0	0	0	0	
3525		12	CONTRIBUTIONS	-5,760		0	0	0	0	
3590		1	EQUIPMENT RENTAL	-78		0	0	0	0	
3595		21	RESIDENT TRANSPORTATION	0		0	0	0	0	
3600		21	MISC INCOME	3		0	0	0	0	
4110			GENERAL & ADMINIST WAGES	164,499	191,625	21	1	17	0	
4111			ADMINISTRATOR WAGES	92,239	92,239	17	1	0	0	
4115			VACATION & SICK - G&A	27,126		21	1	0	0	
4120	4475		EMPLOYEE BENEFITS	75,614	431,027	22	3	0	0	
4125			EMPLOYEE HEPETITIS VACCIN	0		22	3	0	0	
4130			EMPLOYEE SCHOLARSHIP WA	0	103,591	21	1	0	0	
4135			EMPLOYEE SCHOLARSHIP CC	0		23	3	0	0	
4220			DIRECTORS FEES	0	0	18	3	0	0	
4250	4255		OFFICE SUPPLIES	27,669	27,669	21	2	0	0	
4260			TELEPHONE	7,951	7,951	21	3	0	0	
4275			TRAINING & EMPLOYEE DEVL	860	860	23	3	16	0 **	
4280			GENERAL TRAVEL	498	498	24	3	16	0	
4281			MEAL EXPENSE FOR TRAVEL	0		24	3	19	0	
4285			EDUCATION & SEMINAR	0		24	3	19	0 ***	
4290			HELP WANTED ADVERTISING	2,904	55,919	20	3	0	0	-32,940
4291			PROMOTIONAL ADVERTISING	6,518		20	3	25	-6,518	
4292			PUBLIC RELATIONS	2,601		20	3	25	-2,601	
4300			LICENSES & FEES	37,548		20	3	17	0	
4310			DUES & SUBSCRIPTIONS	5,434		20	3	17	-3,334	
4320			CONTRIBUTIONS	0		27	3	20	0	
4350			PROFESSIONAL FEES	2,296	216,339	19	3	22	0	
4355			MEDICAL DIRECTOR	12,061	12,061	9	3	0	0	
4360			UTILIZATION REVIEW	0		10	3	0	0	
4361			OTHER PHYSICIAN FEES			39	3	0	0	
4362			MEDICAL RECORDS CONSULT	720		10	3	0	0	
4363			PHARMACIST FEES	3,836		10	3	0	0	
4364			SOC SERV/ACT CONSULT	3,120	3,120	12	3	0	0	
4370			TV RENTAL	11,017		35	3	5	0	
4380			INCOME TAXES		35,288	27	3	26	0	
4383			BACKGROUND CHECKS	914		20	3	26	0	
4400			PAYROLL TAXES	173,427		22	3	0	0	
4401			PAYROLL TAXES ADMINIST	0		22	3	0	0	
4410			GROUP INSURANCE	151,667		22	3	0	0	
4420			LIABILITY INSURANCE	34,979	34,979	26	3	0	0	
4425			INSURANCE-OWNERS			22	3	21	0	
4430			WORKMENS COMP INSURANC	30,319		22	3	0	0	
4450			CENTRAL OFFICE FEES	214,043		19	3	34	0 **	
4460			BAD DEBTS	35,288		27	3	24	-35,288	
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	31,062	42,079	35	3	16	0	
5110			MAINTENANCE SALARIES	63,009	66,079	6	1	0	0	
5120			MAINTENANCE SICK & VAC	3,070		6	1	0	0	
5130			ELECTRIC	27,069	46,866	5	3	0	0	
5131			NATURAL GAS	11,925		5	3	0	0	
5132			HEATING & DEISEL OIL			5	3	0	0	
5133			WATER & SEWER	7,872		5	3	0	0	
5134			TRASH COLLECTION	11,930	77,739	6	3	0	0	
5140			PROPERTY PLANT REPLACEM	1,091	47,481	6	2	0	0	
5160			GENERAL REPAIR & MAINT	46,390		6	2	0	0	
5165			MAINTENANCE CONTRACTS	65,809		6	3	0	0	
5210			DIETARY WAGES	225,479	239,454	1	1	0	0	
5220			DIETARY SICK & VAC	13,975		1	1	0	0	
5240			DIETARY CONSULTANT	4,583	4,583	2	3	13	0	
5248			FOOD PURCHASES	144,741	144,071	2	2	0	0	
5250			SUPPLIES-DISHWASHING	2,908	22,887	1	2	0	0	
5260			DIETARY REPLACEMENT	2,750		1	2	0	0	
5270			KITCHEN SUPPLIES-PAPER	17,229		1	2	0	0	
5295			MEAL CREDIT	-670		2	2	0	0	
5310			LAUNDRY WAGES	43,809	49,410	4	1	0	0	
5340			LAUNDRY SICK & VAC	5,601		4	1	0	0	
5370			LAUNDRY REPLACEMENT	10,446	11,619	4	2	0	0	
5380			LAUNDRY REIMBURSEMENT			4	3	0	0	
5390			LAUNDRY SUPPLIES	1,173		4	2	0	0	
5410			HOUSEKEEPING WAGES	59,420	64,182	3	1	0	0	
5440			HOUSEKEEPING SICK & VAC	4,762		3	1	0	0	
5480			HOUSEKEEPING SUPPLIES	21,541	22,129	3	2	0	0	
5490			HOUSEKEEPING SUPPLIES-PF	588		3	2	0	0	
6010			RN WAGES-MEDICARE		1,414,666	10	1	0	0	
6020			RN WAGES-NON MEDICARE	249,989		10	1	0	0	
6030			DON WAGES	78,793		10	1	0	0	
6035			ADON	688		10	1	0	0	
6040			RN SICK & VACATION	23,981		10	1	0	0	
6110			LPN WAGES-MEDICARE	268,886		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	15,473		10	1	0	0	
6210			AIDE WAGES-MEDICARE			10	1	0	0	
6220			AIDE WAGES-NON MEDICARE	730,850		10	1	0	0	
6230			WARD CLERKS			10	1	0	0	
6240			AIDE VACATION & SICK	46,006		10	1	0	0	
6245			CONTRACT NURSES-RN	162,628		10	3	0	0	
6246			CONTRACT NURSES-LPN	91,172		10	3	0	0	
6247			CONTRACT NURSES-AIDES	83,313		10	3	0	0	
6250			NURSE AIDE TRAINING WAGES	2,031	2,031	13	1	0	0	
6255			NURSE AID TRAINING EXP	2,868	2,868	13	2	0	0	
6260			NURSE AIDE TRAINING REIMB	0		0	0	0	0	
6270			REHAB WAGES	0		10	1	0	0	
6275			REHAB SICK & VAC	0		10	1	0	0	
6280			NURSING DEPT EDUCATION			23	3	0	0	
6290			NURSING SUPPLIES	53,731	154,970	10	2	0	0	
6295			NURSING SUPPLIES	95,294		10	2	0	0	
6390			REPLACEMENT-NURSING	5,945		10	2	0	0	
6490			NURSING OTHER	0	341,669	10	3	0	0	
7280			DRUG PURCHASES	87,810	93,643	39	2	0	0 ***	
7281			DRUG PURCHASES-OTHER	5,833		39	2			
7380			LABORATORY SERVICES	4,339	4,339	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	54,305	59,769	11	1	0	0	
7540			ACTIVITIES SICK & VAC	5,464		11	1	0	0	
7590			ACTIVITIES SUPPLIES	1,458	1,458	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	229,109	487,629	39	3	0	0 ***	
7660			PT SUPPLIES	0		39	2	0	0	
7710			SOCIAL SERVICE WAGES	35,648	38,715	12	1	0	0	
7720			SOCIAL SERVICE SICK & VAC	3,067		12	1	0	0	
7730			SOCIAL SERVICE EXPENSES	0	0	12	2	0	0	
7740			OT FEE	225,754		39	3	0	0 ***	
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0	
7770			SPEECH THERAPY FEE	32,766		39	3	0	0 ***	
7800			BEAUTICIAN WAGES		0	40	1	0	0	
7810			BEAUTICIAN SICK & VAC			40	1	0	0	
7820			BEAUTICIAN FEES	814	814	40	3	0	0	
7890			BEAUTY SHOP SUPPLIES	51	51	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	329,100	329,100	34	3	0	0	
8120			INTEREST EXPENSE	36,440	36,440	32	3	14	-2,366	
8130			DEPRECIATION	0	0	30	3	9	0	
8150			LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510			INTEREST INCOME	-2,366		32	0	10	0	
9520			MISC NON-OPERATING INCOM	0		0	0	0	0	
9700			INCOME TAXES	0		0	0	0	0	
				4,913,950	5,019,907					
					105,957					
GRAND TOTALS				597,801					-50,107	
				(NET INCOME)						
				0						

1,009	1,009 CASH	936
1,100	1,100 ACCTS RI	197,034
1,101	1,101 ALLOW. F	(71,704)
1,110	1,110 ACCTS RECEIV-M/C	
1,125	1,125 ACCTS RECEIV-IPA	
1,132	1,132 US HHS S	(160,713)
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	2,696
1,300	1,300 DIETARY I	11,673
1,310	1,310 SUPPLIES INVENTORY	
1,320	1,320 LINEN INVENTORY	
1,409	1,409 LAND	0
1,450	1,450 FURNITUF	0
1,460		0
1,475	1,475 BUILDINGS	0
1,490	1,490 ACCUM DI	0
1,530	1,530 RESIDENT	9,393
1,550	1,550 LOAN FEE	0
1,551	1,551 LOAN FEES ADDED	
1,850	1,850 INTERCOI	(5,397,373)
2,010	2,010 ACCOUNT	0
2,100	2,095 BONUSES PAYABLE	
2,100	2,100 ACCRUED	(27,182)
2,100	2,100 PR CLEARING-BENEFITS	
2,100	2,100 PR CLEARING-LABOR	
2,110	2,110 ACCRUED	(115,047)
2,120	2,120 U.C. TAXE	0
2,125	2,125 FICA TAXE	(8,915)
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 ACCRUED	0
2,320	2,320 IPA PAYMI	(8,377)
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	(9,393)
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	4,979,171
	net income	597,801
	balance	0

3,007	3,007 PATIENT I	4,735
3,007	3,007 PATIENT I	11,686
3,007	3,007 PATIENT I	1,289
3,007		0
3,007		
3,007		
3,007		
3,010	3,010 BASIC CH	(3,693,570)
3,020	3,020 BASIC CH	0
3,030	3,030 BASIC CH	0
3,040	ASSESSM	103,591
3,050		0
3,060		0
3,061		0
3,080	3,080 NURSING	(7,991)
3,081	3,081 NURSING	0
3,082	3,082 NURSING	0
3,083	3,083 NURSING	0
3,100	3,100 DRUGS-M	(147,569)
3,101		0
3,110	3,110 PHYSICAL	(1,506,120)
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		0
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 CONTRIBI	(5,760)
3,411	3,411 MEDICARI	0
3,420	3,420 MEDICARI	1,159,019
3,452	3,452 HHS STIM	(291,234)
3,520	3,520 RENT INC	0
3,530	3,530 BEAUTY S	(753)
3,560	ACTIVITY I	(55)
3,570	3,570 VENDING	0
3,590	3,590 EQUIPMEI	(78)
3,595	3,595 RESIDENT	0
3,600	3,600 MISC INC	3
4,110	4,110 G&A WAG	164,499
4,111	4,111 ADMINISTI	92,239
4,115	4,115 G&A PTO	27,126
4,120	4,120 EMPLOYE	75,179
4,121		0
4,130	4,130 EMPLOYE	0
4,135	4,135 EMPLOYE	0
4,250	4,250 OFFICE S	7,474
4,255	4,255 POSTAGE	2,257
4,260	4,260 TELEPHO	7,951
4,275	4,275 TRAINING	860
4,276		59
4,280	4,280 GENERAL	498
4,281	4,281 MEAL EXF	0
4,285	4,285 EDUCATIC	0
4,289	4,289 MEETINGS	0
4,290	4,290 HELP WAI	2,904
4,291	4,291 PROMOTI	6,518
4,292	4,292 PUBLIC R	2,601
4,300	4,300 LICENSE	37,548
4,310	4,310 DUES & S	5,434
4,320	4,320 CONTRIBI	0
4,350	4,350 PROFESS	2,296
4,355	4,355 MEDICAL	12,061
4,362		720
4,363		3,836
4,364	4,364 SOCIAL S	3,120
4,370	4,370 TV RENTA	11,017
4,383	4,383 BACKGRC	914
4,390	4,390 OTHER T/	0
4,400	4,400 PAYROLL	173,427
4,401	4,401 PAYROLL	0
4,410	4,410 GROUP IN	151,667
4,420	4,420 LIABILITY	34,979
4,430	4,430 WORKMA	28,874
4,435	4,435 W/C-FIRS	0
4,436	4,436 DRUG TE	1,386
4,450	4,450 MANAGEM	214,043
4,460	4,460 BAD DEBT	35,288
4,461	4,461 BAD DEBT	74,368
4,470	4,470 LOST ITEI	0
4,475	4,475 UNIFORM	435
4,486	4,486 SERVICE	45,527
4,490	4,490 MISC EXP	77
4,496	4,496 MISC. M.I.	17,938
4,510	4,510 REAL EST	0
4,600	4,600 LEASED E	31,062
5,110	5,110 MAINTENA	63,009
5,120	5,120 MAINTENA	3,070
5,130	5,130 ELECTRIC	27,069
5,131	5,131 NATURAL	11,925
5,133	5,133 WATER &	7,872
5,134	5,134 TRASH C	11,930
5,140	5,140 PROP/PL/	1,091
5,160	5,160 GENERAL	46,390
5,165	5,165 MAINTENA	20,282
5,210	5,210 DIETARY	225,479
5,220	5,220 DIETARY	13,975
5,248	5,248 FOOD PU	144,664
5,250	5,250 SUPPLIES	2,908
5,260	5,260 REPLACE	2,750
5,270	5,270 KITCHEN	17,229
5,295	5,295 MEAL INC	(670)
5,310	5,310 LAUNDRY	43,809
5,340	5,340 LAUNDRY	5,601
5,370	5,370 REPLACE	10,446
5,230	5,230 DIETARY	4,583
5,390	5,390 LAUNDRY	1,173
5,410	5,410 HOUSEKE	59,420
5,440	5,440 HOUSEKE	4,762
5,480	5,480 SUPPLIES	21,541
5,490	5,490 SUPPLIES	588
6,020	6,020 RN WAGE	249,989
6,030	6,030 DON WAG	78,793
6,035	6,035 ADON WA	688
6,040	6,040 RN PTO &	23,981
6,120	6,120 LPN WAG	268,886
6,140	6,140 LPN PTO	15,473
6,220	6,220 AIDES WA	730,850
6,240	6,240 AIDES PT	46,006
6,245	RN CONT	162,628
6,246	LPN CONT	91,172
6,247	AIDES CO	83,313
6,250		2,031
6,255		2,868
6,260		0
6,270	6,270 REHAB W	0
6,275	6,275 REHAB PT	0
6,290	6,290 NURSING	53,731
6,295	6,295 NURSING	95,294
6,390	6,390 REPLACE	5,945
6,490	6,490 OTHER	0
7,280	7,280 DRUG PU	87,810
7,281	7,281 DRUG PU	5,833
7,380	7,380 LABORAT	1,421
7,391	7,390 X-RAY SE	2,918
7,393		0
7,510	7,510 ACTIVITIE	54,305
7,540	7,540 ACTIVITIE	5,464
7,590	7,590 ACTIVITIE	1,458
7,620	7,620 PHYSICAL	229,109
7,660	7,660 P.T. SUPF	0
7,710	7,710 SOCIAL S	35,648
7,720	7,720 SOCIAL S	3,067
7,730	7,730 SOCIAL S	0
7,740	7,740 OCCUPAT	225,754
7,750		
7,770	7,770 SPEECH	32,766
7,820	7,820 BEAUTICI	814
7,890		51
7,960		0
8,120	8,120 INTEREST	0
8,125		36,440
8,130	8,130 DEPRECI	0
8,150		0
9,510	9,510 INTEREST	(2,366)
9,520	9,520 MISC NON	0
9,530	4,220	0
	8,100	329,100
	9,702	0
	5,230	0
		597,801

Expenses Fixed Assets

0

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 162

BALANCE SHEET TOTAL 0

Heritage Manor Gibson City
IDPH ID# 48116
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	$	93,643
Purchased Hospital Services		2,365
Purchased Laboratory Services		1,421
Purchased Radiology Services		553
Amount Reclassified to Line 39	$	97,982

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

Line Item		
Provider Participation Fee - $1.50	$	(32,940)
Provider Assesment Fee - $6.07		(103,591)
	$	(136,531)
Provider Participation Fee	$	136,531

3. Schedule V - Line 10 to Line 10A - Reclass Pharmacy Consultant Cost

Line Item		
Pharmacy consultant expense	$	3,836