		FOR BHF USE					

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

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

I. IDPH License ID Number: 0048900

Facility Name: Heritage Health Litchfield

Address: 628 S Illinois St (Number) Litchfield (City) 62056 (Zip Code)

County: Montgomery

Telephone Number: (217) 324-2153 Fax # ( )

HFS ID Number:

Date of Initial License for Current Owners: July 2007

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider	(Signed) (Date)
	(Type or Print Name) David M Underwood
	(Title) EVP & CFO
Paid Preparer	(Signed) (Date)
	(Print Name and Title)
	(Firm Name & Address)
	(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Heritage Health Litchfield # 0048900 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	92	Skilled (SNF)	92	33,672	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	92	TOTALS	92	33,672	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	13,772	5,709	2,625	22,106	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,772	5,709	2,625	22,106	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.65%

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 2007

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 92 and days of care provided 2,625

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 Litchfield # 0048900 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	203,163	13,991	6,126	223,280		223,280	4,489	227,769			1
2	Food Purchase		179,314		179,314		179,314	(16)	179,298			2
3	Housekeeping	109,124	29,531		138,655		138,655	5,984	144,639			3
4	Laundry	40,551	17,846		58,397		58,397	428	58,825			4
5	Heat and Other Utilities			82,865	82,865		82,865	1,425	84,290			5
6	Maintenance	71,428	27,962	91,039	190,429		190,429	17,464	207,893			6
7	Other (specify):*											7
8	**TOTAL General Services**	424,266	268,644	180,030	872,940		872,940	29,774	902,714			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	1,777,336	120,968	6,023	1,904,327	(4,767)	1,899,560	7,445	1,907,005			10
10a	Therapy		137,683	20,152	157,835	(152,922)	4,913		4,913			10a
11	Activities	44,110	854		44,964		44,964	5	44,969			11
12	Social Services	46,400		1,927	48,327		48,327	128	48,455			12
13	CNA Training	1,342			1,342		1,342		1,342			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,869,188	259,505	52,102	2,180,795	(157,689)	2,023,106	7,578	2,030,684			16
	C. General Administration											
17	Administrative	86,416			86,416		86,416		86,416			17
18	Directors Fees											18
19	Professional Services			256,175	256,175		256,175	(237,886)	18,289			19
20	Dues, Fees, Subscriptions & Promotions			197,960	197,960	(174,949)	23,011	(8,674)	14,337			20
21	Clerical & General Office Expenses	152,047	17,631	10,005	179,683		179,683	382,962	562,645			21
22	Employee Benefits & Payroll Taxes			425,568	425,568		425,568	38,566	464,134			22
23	Inservice Training & Education			91	91		91	1,141	1,232			23
24	Travel and Seminar			1,520	1,520		1,520	3,479	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			53,589	53,589		53,589	63,889	117,478			26
27	Other (specify):*			77,283	77,283		77,283	(77,283)				27
28	**TOTAL General Administration**	238,463	17,631	1,022,191	1,278,285	(174,949)	1,103,336	166,194	1,269,530			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,531,917	545,780	1,254,323	4,332,020	(332,638)	3,999,382	203,546	4,202,928			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 Litchfield #0048900 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		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
30	Depreciation							198,816	198,816			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,699	44,699		44,699	74,718	119,417			32
33	Real Estate Taxes							70,731	70,731			33
34	Rent-Facility & Grounds			446,760	446,760		446,760	(440,113)	6,647			34
35	Rent-Equipment & Vehicles			28,860	28,860		28,860	11,766	40,626			35
36	Other (specify):*											36
37	**TOTAL Ownership**			520,319	520,319		520,319	(84,082)	436,237			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			348,159	348,159	157,689	505,848	183,419	689,267			39
40	Barber and Beauty Shops	6,260	201		6,461		6,461		6,461			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					174,949	174,949		174,949			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	6,260	201	348,159	354,620	332,638	687,258	183,419	870,677			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,538,177	545,981	2,122,801	5,206,959		5,206,959	302,883	5,509,842			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 Litchfield # 0048900 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	(2,762)			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	(4,112)			17
18	Fines and Penalties				18
19	Entertainment	(1,310)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,274)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(77,283)			24
25	Fund Raising, Advertising and Promotional	(5,446)			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)**	$ (93,187)		$	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)	396,070		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 396,070		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 302,883		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

STATE OF ILLINOIS

Heritage Health Litchfield

ID# 0048900

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		(2,274)	19	11
12		(2,762)	32	12
13		(77,283)	27	13
14		(5,446)	20	14
15		(4,112)	20	15
16		0	27	16
17		(1,310)	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	(93,187)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Litchfield # 0048900 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	4,489	0	0	0	0	0	0	0	0	4,489	1
2	Food Purchase	0	0	(16)	0	0	0	0	0	0	0	0	(16)	2
3	Housekeeping	0	0	5,984	0	0	0	0	0	0	0	0	5,984	3
4	Laundry	0	0	428	0	0	0	0	0	0	0	0	428	4
5	Heat and Other Utilities	0	0	1,425	0	0	0	0	0	0	0	0	1,425	5
6	Maintenance	0	0	17,464	0	0	0	0	0	0	0	0	17,464	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	29,774	0	0	0	0	0	0	0	0	29,774	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(15,799)	23,244	0	0	0	0	0	0	0	0	7,445	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	5	0	0	0	0	0	0	0	0	5	11
12	Social Services	0	0	128	0	0	0	0	0	0	0	0	128	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(15,799)	23,377	0	0	0	0	0	0	0	0	7,578	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	(2,274)	(250,848)	15,236	0	0	0	0	0	0	0	0	(237,886)	19
20	Fees, Subscriptions & Promotions	(9,558)	0	884	0	0	0	0	0	0	0	0	(8,674)	20
21	Clerical & General Office Expenses	0	0	382,962	0	0	0	0	0	0	0	0	382,962	21
22	Employee Benefits & Payroll Taxes	0	0	38,566	0	0	0	0	0	0	0	0	38,566	22
23	Inservice Training & Education	0	(72)	1,213	0	0	0	0	0	0	0	0	1,141	23
24	Travel and Seminar	(1,310)	0	4,789	0	0	0	0	0	0	0	0	3,479	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	63,889	0	0	0	0	0	0	0	0	63,889	26
27	Other (specify):*	(77,283)	0	0	0	0	0	0	0	0	0	0	(77,283)	27
28	**TOTAL General Administration**	(90,425)	(250,920)	507,539	0	0	0	0	0	0	0	0	166,194	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(90,425)	(266,719)	560,690	0	0	0	0	0	0	0	0	203,546	29

Facility Name & ID Number Heritage Health Litchfield # 0048900 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	177,228	0	21,588	0	0	0	0	0	0	0	198,816	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,762)	75,057	0	2,423	0	0	0	0	0	0	0	74,718	32
33	Real Estate Taxes	0	70,731	0	0	0	0	0	0	0	0	0	70,731	33
34	Rent-Facility & Grounds	0	(446,760)	0	6,647	0	0	0	0	0	0	0	(440,113)	34
35	Rent-Equipment & Vehicles	0	0	0	11,766	0	0	0	0	0	0	0	11,766	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,762)	(123,744)	0	42,424	0	0	0	0	0	0	0	(84,082)	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	183,246	0	173	0	0	0	0	0	0	0	183,419	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	183,246	0	173	0	0	0	0	0	0	0	183,419	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(93,187)	(207,217)	560,690	42,597	0	0	0	0	0	0	0	302,883	45

Facility Name & ID Number Heritage Health Litchfield # 0048900 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		$ (15,799)	$ (15,799)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy		(72)	(72)	2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy		183,246	183,246	3
4	V	19	Adjustment for Related Organization	250,848	Heritage Operations Group, LLC			(250,848)	4
5	V								5
6	V	34	Adjustment for Related Organization	446,760	Heritage Manor Real Estate, LLC			(446,760)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		70,731	70,731	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		74,845	74,845	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		177,228	177,228	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		212	212	10
11	V								11
12	V								12
13	V								13
14	Total			$ 697,608			$ 490,391	$ * (207,217)	14

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

Facility Name & ID Number Heritage Health Litchfield # 0048900 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Heritage Operations Group		$ 4,489	$ 4,489	15
16	V	2	Food Purchase		Heritage Operations Group		(16)	(16)	16
17	V	3	Housekeeping		Heritage Operations Group		5,984	5,984	17
18	V	4	Laundry		Heritage Operations Group		428	428	18
19	V	5	Heat & Other Utilities		Heritage Operations Group		1,425	1,425	19
20	V	6	Maintenance		Heritage Operations Group		17,464	17,464	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		23,244	23,244	23
24	V	11	Activities		Heritage Operations Group		5	5	24
25	V	12	Social Service		Heritage Operations Group		128	128	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		15,236	15,236	31
32	V	20	Fees, Subscription, Promotions		Heritage Operations Group		884	884	32
33	V	21	Clerical & General Office Expenses		Heritage Operations Group		382,962	382,962	33
34	V	22	Employee Benefits & Payroll Taxes		Heritage Operations Group		38,566	38,566	34
35	V	23	Inservice Training & Education		Heritage Operations Group		1,213	1,213	35
36	V	24	Travel and Seminar		Heritage Operations Group		4,789	4,789	36
37	V	25	Other Admin. Staff Transportation		Heritage Operations Group		0		37
38	V	26	Insurance-Prop.Liab.Malpract		Heritage Operations Group		63,889	63,889	38
39	Total			$			$ 560,690	$ * 560,690	39

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

Facility Name & ID Number Heritage Health Litchfield # 0048900 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27		$	Heritage Operations Group		$ 0	$	15
16	V	30			Heritage Operations Group		21,588	21,588	16
17	V	31			Heritage Operations Group		0		17
18	V	32			Heritage Operations Group		2,423	2,423	18
19	V	33			Heritage Operations Group		0		19
20	V	34			Heritage Operations Group		6,647	6,647	20
21	V	35			Heritage Operations Group		11,766	11,766	21
22	V	36			Heritage Operations Group		0		22
23	V	38			Heritage Operations Group		0		23
24	V	39			Heritage Operations Group		173	173	24
25	V	40			Heritage Operations Group		0		25
26	V	41			Heritage Operations Group		0		26
27	V	42			Heritage Operations Group		0		27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 42,597	$ * 42,597	39

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

Facility Name & ID Number Heritage Health Litchfield # 0048900 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	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 Litchfield # 0048900 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	92	$ 4,489	1
2	2	Food Purchase	Beds	2,493	25	(423)	0	92	(16)	2
3	3	Housekeeping	Beds	2,493	25	162,156	0	92	5,984	3
4	4	Laundry	Beds	2,493	25	11,591	0	92	428	4
5	5	Heat & Other Utilities	Beds	2,493	25	38,605	0	92	1,425	5
6	6	Maintenance	Beds	2,493	25	473,233	88,567	92	17,464	6
7	7	Other	Beds	2,493	25	0	0	92	0	7
8	9	Medical Director	Beds	2,493	25	0	0	92	0	8
9	10	Nursing & Medical Records	Beds	2,493	25	629,872	35,401	92	23,244	9
10	11	Activities	Beds	2,493	25	129	0	92	5	10
11	12	Social Service	Beds	2,493	25	3,478	3,478	92	128	11
12	13	Nurse Aide Training	Beds	2,493	25	0	0	92	0	12
13	14	Program Transportation	Beds	2,493	25	0	0	92	0	13
14	15	Other	Beds	2,493	25	0	0	92	0	14
15	17	Administrative	Beds	2,493	25	0	0	92	0	15
16	18	Directors Fees	Beds	2,493	25	0	0	92	0	16
17	19	Professional Services	Beds	2,493	25	412,869	0	92	15,236	17
18	20	Fees, Subscription, Promotions	Beds	2,493	25	23,945	0	92	884	18
19	21	Clerical & General Office Expense	Beds	2,493	25	10,377,428	9,978,005	92	382,962	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,493	25	1,045,059	0	92	38,566	20
21	23	Inservice Training & Education	Beds	2,493	25	32,865	0	92	1,213	21
22	24	Travel and Seminar	Beds	2,493	25	129,776	0	92	4,789	22
23	25	Other Admin. Staff Transportatio	Beds	2,493	25	0	0	92	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,493	25	1,731,253	0	92	63,889	24
25	TOTALS					$ 15,193,470	$ 10,226,789		$ 560,690	25

Facility Name & ID Number Heritage Health Litchfield # 0048900 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	$	$	92	$	1
2	30	Depreciation	Beds	2,493	25	584,981		92	21,588	2
3	31	Amortization of Pre-Op & Org	Beds	2,493	25			92		3
4	32	Interest	Beds	2,493	25	65,658		92	2,423	4
5	33	Real Estate Taxes	Beds	2,493	25			92		5
6	34	Rent-Facility & Grounds	Beds	2,493	25	180,106		92	6,647	6
7	35	Rent-Equipment & Vehicles	Beds	2,493	25	318,843		92	11,766	7
8	36	Other	Beds	2,493	25			92		8
9	38	Medically Nec Transportation	Beds	2,493	25			92		9
10	39	Ancillary Service Centers	Beds	2,493	25	4,685		92	173	10
11	40	Barber and Beauty Shops	Beds	2,493	25			92		11
12	41	Coffee and Gift Shops	Beds	2,493	25			92		12
13	42	Other	Beds	2,493	25			92		13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,154,273	$		$ 42,597	25

Facility Name & ID Number Heritage Health Litchfield # 0048900 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			$	$			$ 74,845	1
2	Busey Bank		xx	Loan Fee Amortization							212	2
3												3
4												4
5												5
	Working Capital											
6	Busey Bank		xx	Working Capital							44,699	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 119,756	9
	B. Non-Facility Related*											
10	Interest Income										(2,762)	10
11												11
12	Allocated Corporate										2,423	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (339)	14
15	TOTALS (line 9+line14)						$	$			$ 119,417	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 Litchfield # 0048900 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

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

Item		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	70,731	2
3. Under or (over) accrual (line 2 minus line 1).	$	70,731	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.	$	70,731	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2015	74,457	8
2016	76,563	9
2017	78,056	10
2018	78,070	11
2019	70,731	12

FOR BHF USE ONLY

Line	Description		Line
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 Litchfield COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0048900

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.	1504279009		$ 67,622.74	$ 67,623.00
2.	1504278012		$ 222.24	$ 222.00
3.	1504279015		$ 2,886.10	$ 2,886.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 70,731.08	$ 70,731.00

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 Litchfield # 0048900 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,500 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1996	$ 6,816	1
2					2
3	TOTALS			$ 6,816	3

Facility Name & ID Number Heritage Health Litchfield # 0048900 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	92				$ 3,364,350	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1996 Improvements			1996	5,192						9
10	1997 Improvements			1997	13,647						10
11	1998 Improvements			1998	66,554						11
12	1999 Improvements			1999	15,346						12
13	2000 Improvements			2000	13,273						13
14	2001 Improvements			2001	4,860						14
15	2002 Improvements			2002	6,820						15
16	2003 Improvements			2003	13,771						16
17	2004 Improvements			2004	47,596						17
18	2005 Improvements			2005	135,427						18
19	2006 Improvements			2006	105,774						19
20	2007 Improvements			2007	52,894						20
21	2008 Improvements			2008	86,096						21
22	2009 Improvements			2009	524,594						22
23	2010 Improvements			2010	36,378						23
24	2011 Improvements			2011	66,259						24
25	2012 Improvements			2012	9,373						25
26	2013 Improvements			2013	13,380						26
27	2014 Improvements			2014	37,293						27
28											28
29	Replace (5) PTAC units			2015	2,885						29
30	Exterior brick repair - cut outs and replacments			2015	11,760						30
31	Furnish and install a roof fitted exhaust fan			2015	5,832						31
32											32
33											33
34	C/O Allocation					21,588		21,588			34
35	Book Depreciation					164,667		164,667			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 Litchfield # 0048900 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	No 2016 Improvements	2016							38
39									39
40	Installed water meter - back hall	2017	3,229						40
41									41
42	Installed (4) PTAC units	2018	3,632						42
43	Replace kitchen floor drain - cut out concrete, disconnent	2018	32,574						43
44	and reconnect new drain to sewer line. Fill in with new								44
45	concrete								45
46									46
47	Replace (5) PTAC units	2019	5,351						47
48	Replace disposer	2019	2,535						48
49	Roof repairs - partial building	2019	16,839						49
50	Boiler and Boiler Control replacements - Northeast Boiler Room	2019	37,158						50
51									51
52	Rebuild circulating pump	2020	3,126						52
53	Replace service area doors	2020	17,800						53
54	Replace windows throughout facility	2020	15,589						54
55	Remove all flooring tile and mastic in the Oakdale wing and repla	2020	99,582						55
56									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)		$ 4,876,769	$ 186,255		$ 186,255	$	$	70

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

Facility Name & ID Number Heritage Health Litchfield # 0048900 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	$ 836,410	$ 12,561	$ 12,561	$		$	71
72	Current Year Purchases	15,787						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 852,197	$ 12,561	$ 12,561	$		$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2009 Turtletop bus	2008	$ 60,815	$	$	$		$	76
77		2008 Grand Caravan	2011	31,061						77
78										78
79										79
80	TOTALS			$ 91,876	$	$	$		$	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)	$ 5,827,658	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 198,816	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 198,816	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 Litchfield # 0048900 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: $ 28,860 Description: Televisions and office machines
    (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 Litchfield # 0048900 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)		1,342		1,342
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 1,342	$	$ 1,342
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,342			

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	$		$ 121,414	$		$ 121,414	1
2	Licensed Speech and Language Development Therapist		hrs			60,663			60,663	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			166,082	146		166,228	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				137,537		137,537	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					20,152			20,152	13
14	TOTAL			$		$ 368,311	$ 137,683		$ 505,994	14

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

Facility Name & ID Number Heritage Health Litchfield # 0048900 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,014	$	1
2	Cash-Patient Deposits	18,825		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	24,018		3
4	Supply Inventory (priced at FIFO)	31,564		4
5	Short-Term Investments			5
6	Prepaid Insurance	3,541		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	2,290,121		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,369,083	$	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)**	$ 2,369,083	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,825		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	247,229		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,433		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	9,111		36
37	Deferred Stimulus	274,419		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 553,017	$	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)**	$ 553,017	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,816,066	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,369,083	$	48

*(See instructions.)

Facility Name & ID Number Heritage Health Litchfield # 0048900 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,801,590	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,801,590	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	14,476	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)**	$ 14,476	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,816,066	24 *

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

Facility Name & ID Number Heritage Health Litchfield # 0048900 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	$ 4,715,274	1
2	Discounts and Allowances for all Levels	(1,115,829)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,599,445	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,015,713	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,015,713	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	376,056	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	5,404	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	221,832	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	26	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 603,318	23
	D. Non-Operating Revenue		
24	Contributions	197	24
25	Interest and Other Investment Income***	2,762	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,959	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)**	$ 5,221,435	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	872,940	31
32	Health Care	2,180,795	32
33	General Administration	1,278,285	33
	B. Capital Expense		
34	Ownership	520,319	34
	C. Ancillary Expense		
35	Special Cost Centers	354,620	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)***	$ 5,206,959	40
41	**Income before Income Taxes (line 30 minus line 40)****	14,476	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 14,476	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 Litchfield # 0048900 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	574	598	$ 86,576	$ 144.78	1
2	Assistant Director of Nursing	2,074	2,160	59,709	27.64	2
3	Registered Nurses	7,175	7,474	234,174	31.33	3
4	Licensed Practical Nurses	13,985	14,568	392,820	26.96	4
5	CNAs & Orderlies	52,272	54,450	940,254	17.27	5
6	CNA Trainees	148	154	1,342	8.71	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,989	2,072	63,803	30.79	8
9	Activity Director					9
10	Activity Assistants	3,369	3,509	44,110	12.57	10
11	Social Service Workers	1,951	2,033	46,400	22.82	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,350	14,948	203,163	13.59	15
16	Dishwashers					16
17	Maintenance Workers	3,850	4,011	71,428	17.81	17
18	Housekeepers	8,565	8,922	109,124	12.23	18
19	Laundry	3,785	3,943	40,551	10.28	19
20	Administrator	2,023	2,108	86,416	40.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,703	6,983	152,047	21.77	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) Beauticians	400	417	6,260	15.01	33
34	TOTAL (lines 1 - 33)	123,213	128,350	$ 2,538,177 *	$ 19.78	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$ 6,126	L1 C3	35
36	Medical Director		24,000	L9 C3	36
37	Medical Records Consultant		1,015	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,767	L10A C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		1,927	L12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 37,835		49

C. CONTRACT NURSES

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

Facility Name & ID Number Heritage Health Litchfield # 0048900 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jamie Evans	Administrator		$ 86,416
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 86,416

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	$ 253,901
Legal adj to Zero		2,274
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 256,175

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 23,453
Unemployment Compensation Insurance	(671)
FICA Taxes	194,171
Employee Health Insurance	167,470
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	41,145
Central Office Allocation	38,566
TOTAL (agree to Schedule V, line 22, col.8)	$ 464,134

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,911
Health Care Worker Background Check (Indicate # of checks performed)	1,273
Patient Background Checks	
PR	2,147
Dues & Subscriptions	7,332
License & Fees	5,049
Central Office Allocation	884
Less: Public Relations Expense	(2,147)
Non-allowable advertising	(4,112)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,337

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	970
	0
Seminar Expense	550
	3,479
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,999

**See instructions.

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI - $6,440**

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

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

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

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

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **174,949**
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. $ **2,131**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **NA**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **None Claimed**
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number			Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg Line #	Adjustment Amount	
1009			PETTY CASH	1,014						
1010			CASH IN BANK							
1040			CASH IN BANK-PAYROLL							
1100			ACCOUNTS RECEIVABLE	24,018						
1110			MEDICARE RECEIVABLES							
1125			IPA INCOME RECEIVABLE							
1130			MEDICARE COST REPORT							
1132			US HHS STIMULUS SETTLEME	-274,419						
1140			UNAPPLIED CASH RECEIPTS							
1145			A/R SUSPENSE-REFUNDS							
1190			ACCRUED INTEREST REC							
1200			PREPAID INSURANCE	3,541						
1220			OTHER PREPAID EXPENSES							
1300			FOOD INVENTORY	31,564						
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	18,825						
1550			LOAN FEES	0						
1560			REAL ESTATE TAX ESCROW							
1575			REIMBURSABLE PURCHASES							
1850			INTRACOMPANY	2,290,121						
2010			ACCOUNTS PAYABLE	0						
2095			BONUSES PAYABLE							
2100			ACCRUED PAYROLL	-96,327						
2110			ACCRUED VACATION PAY	-150,902						
2120			UC TAXES PAYABLE							
2125			FICA TAX PAYABLE	-3,433	-3,433					
2130			FIT PAYABLE							
2140			STATE W/H PAYABLE		0					
2145			EARNED INCOME CREDIT							
2150			UC FED CREDIT REDUCTION							
2230			PAYROLL SAVINGS							
2235			IRA W/HOLDINGS							
2240			UNITED WAY							
2245			GROUP INSURANCE PAYABLE							
2246			GROUP INSURANCE PAYABLE-CAFETERIA							
2260			WAGE GARNISHMENTS							
2280			MISC PAYROLL DEDUCTIONS							
2300			ACCRUED INTEREST PAYABLE	0						
2310			SALES TAX PAYABLE							
2320			IPA PAYMENTS PAYABLE	-9,111						
2350			REAL ESTATE TAX PAYABLE	0						
2385			ACTIVITY FUND	0						
2390			SECURITY DEPOSITS	0						
2391			VOLUNTEER FUND							
2393			HEART FUND/MDAR							
2395			DEFERRED INC EMP & MEM							
2400			CURRENT PORTION LT DEBT							
2460			INCOME TAXES PAYABLE							
2512			DUE TO RESIDENTS	-18,825						
2600			MORTGAGE PAYABLE	0						
2650			EQUIPMENT LOAN PAYABLE							
2695			CURRENT PORTION LT DEBT							
2696			DEFERRED INCOME TAXES							
2710			COMMON STOCK							
2720			RETAINED EARNINGS	-1,801,590						
2970			PROFIT/LOSS FOR PERIOD	-14,476						
3007.1			PATIENT DAYS-PRIVATE	5,709						
3007.2			PATIENT DAYS-IPA	13,772						
3007.3			PATIENT DAYS-MEDICARE	2,625						
3007.4			PATIENT DAYS-CONVERSION							
3007.5			PATIENT DAYS-LICENSED							
3007.6			PATIENT DAYS-TOTAL							
3010		1	BASIC CHARGE-PRIVATE & VA	-4,705,997		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	-9,277		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	-221,832		0	0	0	0	
3101		17	DRUGS-OTHER							
3110		6	PT-PRIVATE	-1,015,713		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	124,441						
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	1,115,829		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	-376,056		42	3	0	0	
3520		16	RENT INCOME	0		6	0	6	0	
3530		13	BEAUTY SHOP	-5,404		0	0	0	0	
3560		12	ACTIVITY FUND INCOME			0	0	0	0	
3570		12	VENDING INCOME/EXPENSE	0		0	0	0	0	
3580		12	CONTRIBUTIONS	-197		0	0	0	0	
3590		1	EQUIPMENT RENTAL	0		0	0	0	0	
3595		21	RESIDENT TRANSPORTATION	0		0	0	0	0	
3600		21	MISC INCOME	-26		0	0	0	0	
4110			GENERAL & ADMINIST WAGES	132,818	152,047	21	1	17	0	
4111			ADMINISTRATOR WAGES	86,416	86,416	17	1	0	0	
4115			VACATION & SICK - G&A	19,229		21	1	0	0	
4120	4475		EMPLOYEE BENEFITS	41,145	425,568	22	3	0	0	
4125			EMPLOYEE HEPETITIS VACCIN	0		22	3	0	0	
4130			EMPLOYEE SCHOLARSHIP WA	0	124,441	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	17,631	17,631	21	2	0	0	
4260			TELEPHONE	10,005	10,005	21	3	0	0	
4275			TRAINING & EMPLOYEE DEVL	91	91	23	3	16	0 **	
4280			GENERAL TRAVEL	970	1,520	24	3	16	0	
4281			MEAL EXPENSE FOR TRAVEL	0		24	3	19	0	
4285			EDUCATION & SEMINAR	550		24	3	19	-1,310 ***	
4290			HELP WANTED ADVERTISING	3,911	73,519	20	3	0	0	-50,508
4291			PROMOTIONAL ADVERTISING	3,299		20	3	25	-3,299	
4292			PUBLIC RELATIONS	2,147		20	3	25	-2,147	
4300			LICENSES & FEES	55,557		20	3	17	0	
4310			DUES & SUBSCRIPTIONS	7,332		20	3	17	-4,112	
4320			CONTRIBUTIONS	0		27	3	20	0	
4350			PROFESSIONAL FEES	5,327	256,175	19	3	22	-2,274	
4355			MEDICAL DIRECTOR	24,000	24,000	9	3	0	0	
4360			UTILIZATION REVIEW	0		10	3	0	0	
4361			OTHER PHYSICIAN FEES			39	3	0	0	
4362			MEDICAL RECORDS CONSULT	1,015		10	3	0	0	
4363			PHARMACIST FEES	4,767		10	3	0	0	
4364			SOC SERV/ACT CONSULT	1,927	1,927	12	3	0	0	
4370			TV RENTAL	13,868		35	3	5	0	
4380			INCOME TAXES		77,283	27	3	26	0	
4383			BACKGROUND CHECKS	1,273		20	3	26	0	
4400			PAYROLL TAXES	193,500		22	3	0	0	
4401			PAYROLL TAXES ADMINIST	0		22	3	0	0	
4410			GROUP INSURANCE	167,470		22	3	0	0	
4420			LIABILITY INSURANCE	53,589	53,589	26	3	0	0	
4425			INSURANCE-OWNERS			22	3	21	0	
4430			WORKMENS COMP INSURANC	23,453		22	3	0	0	
4450			CENTRAL OFFICE FEES	250,848		19	3	34	0 **	
4460			BAD DEBTS	77,283		27	3	24	-77,283	
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	14,992	28,860	35	3	16	0	
5110			MAINTENANCE SALARIES	67,161	71,428	6	1	0	0	
5120			MAINTENANCE SICK & VAC	4,267		6	1	0	0	
5130			ELECTRIC	40,972	82,865	5	3	0	0	
5131			NATURAL GAS	17,019		5	3	0	0	
5132			HEATING & DEISEL OIL			5	3	0	0	
5133			WATER & SEWER	24,874		5	3	0	0	
5134			TRASH COLLECTION	5,457	91,039	6	3	0	0	
5140			PROPERTY PLANT REPLACEM	1,413	27,962	6	2	0	0	
5160			GENERAL REPAIR & MAINT	26,549		6	2	0	0	
5165			MAINTENANCE CONTRACTS	85,582		6	3	0	0	
5210			DIETARY WAGES	187,892	203,163	1	1	0	0	
5220			DIETARY SICK & VAC	15,271		1	1	0	0	
5240			DIETARY CONSULTANT	6,126	6,126	2	3	13	0	
5248			FOOD PURCHASES	181,445	179,314	2	2	0	0	
5250			SUPPLIES-DISHWASHING	1,226	13,991	1	2	0	0	
5260			DIETARY REPLACEMENT	1,013		1	2	0	0	
5270			KITCHEN SUPPLIES-PAPER	11,752		1	2	0	0	
5295			MEAL CREDIT	-2,131		2	2	0	0	
5310			LAUNDRY WAGES	38,949	40,551	4	1	0	0	
5340			LAUNDRY SICK & VAC	1,602		4	1	0	0	
5370			LAUNDRY REPLACEMENT	9,738	17,846	4	2	0	0	
5380			LAUNDRY REIMBURSEMENT			4	3	0	0	
5390			LAUNDRY SUPPLIES	8,108		4	2	0	0	
5410			HOUSEKEEPING WAGES	98,720	109,124	3	1	0	0	
5440			HOUSEKEEPING SICK & VAC	10,404		3	1	0	0	
5480			HOUSEKEEPING SUPPLIES	29,531	29,531	3	2	0	0	
5490			HOUSEKEEPING SUPPLIES-PF	0		3	2	0	0	
6010			RN WAGES-MEDICARE		1,777,336	10	1	0	0	
6020			RN WAGES-NON MEDICARE	222,015		10	1	0	0	
6030			DON WAGES	86,576		10	1	0	0	
6035			ADON	59,709		10	1	0	0	
6040			RN SICK & VACATION	12,159		10	1	0	0	
6110			LPN WAGES-MEDICARE	367,279		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	25,541		10	1	0	0	
6210			AIDE WAGES-MEDICARE			10	1	0	0	
6220			AIDE WAGES-NON MEDICARE	868,799		10	1	0	0	
6230			WARD CLERKS			10	1	0	0	
6240			AIDE VACATION & SICK	71,455		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	1,342	1,342	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	59,071		10	1	0	0	
6275			REHAB SICK & VAC	4,732		10	1	0	0	
6280			NURSING DEPT EDUCATION			23	3	0	0	
6290			NURSING SUPPLIES	15,940	120,968	10	2	0	0	
6295			NURSING SUPPLIES	99,974		10	2	0	0	
6390			REPLACEMENT-NURSING	5,054		10	2	0	0	
6490			NURSING OTHER	241	6,023	10	3	0	0	
7280			DRUG PURCHASES	137,537	137,683	39	2	0	0 ***	
7281			DRUG PURCHASES-OTHER	0		39	2			
7380			LABORATORY SERVICES	20,152	20,152	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	42,512	44,110	11	1	0	0	
7540			ACTIVITIES SICK & VAC	1,598		11	1	0	0	
7590			ACTIVITIES SUPPLIES	854	854	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	166,082	348,159	39	3	0	0 ***	
7660			PT SUPPLIES	146		39	2	0	0	
7710			SOCIAL SERVICE WAGES	42,168	46,400	12	1	0	0	
7720			SOCIAL SERVICE SICK & VAC	4,232		12	1	0	0	
7730			SOCIAL SERVICE EXPENSES	0	0	12	2	0	0	
7740			OT FEE	121,414		39	3	0	0 ***	
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0	
7770			SPEECH THERAPY FEE	60,663		39	3	0	0 ***	
7800			BEAUTICIAN WAGES	6,260	6,260	40	1	0	0	
7810			BEAUTICIAN SICK & VAC			40	1	0	0	
7820			BEAUTICIAN FEES		0	40	3	0	0	
7890			BEAUTY SHOP SUPPLIES	201	201	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	446,760	446,760	34	3	0	0	
8120			INTEREST EXPENSE	44,699	44,699	32	3	14	-2,762	
8130			DEPRECIATION	0	0	30	3	9	0	
8150			LOAN FEE AMORTIZATION	0		32	3	0	0	
9510			INTEREST INCOME	-2,762		32	0	10	0	
9520			MISC NON-OPERATING INCOM	0		0	0	0	0	
9700			INCOME TAXES	0		0	0	0	0	
				5,079,756	5,206,959					
					127,203					
GRAND TOTALS				-14,476					-93,187	
				(NET INCOME)						
				0						

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 162

BALANCE SHEET TOTAL 0

1,009	1,009 CASH	1,014
1,100	1,100 ACCTS RE	100,743
1,101	1,101 ALLOW. F	(76,725)
1,110	1,110 ACCTS RECEIV-M/C	
1,125	1,125 ACCTS RECEIV-IPA	
1,132	1,132 US HHS S	(274,419)
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	3,541
1,300	1,300 DIETARY I	31,564
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	18,825
1,550	1,550 LOAN FEE	0
1,551	1,551 LOAN FEES ADDED	
1,850	1,850 INTERCOI	2,290,121
2,010	2,010 ACCOUNT	0
2,100	2,095 BONUSES PAYABLE	
2,100	2,100 ACCRUED	(96,327)
2,100	2,100 PR CLEARING-BENEFITS	
2,100	2,100 PR CLEARING-LABOR	
2,110	2,110 ACCRUED	(150,902)
2,120	2,120 U.C. TAXE	0
2,125	2,125 FICA TAXE	(3,433)
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	(9,111)
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	(18,825)
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	(1,801,590)
	net income	(14,476)
	balance	0

3,007	3,007 PATIENT D	5,709
3,007	3,007 PATIENT D	13,772
3,007	3,007 PATIENT D	2,625
3,007		0
3,007		
3,007		
3,007		
3,010	3,010 BASIC CH	(4,705,997)
3,020	3,020 BASIC CH	0
3,030	3,030 BASIC CH	0
3,040	ASSESSM	124,441
3,050		0
3,060		0
3,061		0
3,080	3,080 NURSING	(9,277)
3,081	3,081 NURSING	0
3,082	3,082 NURSING	0
3,083	3,083 NURSING	0
3,100	3,100 DRUGS-M	(221,832)
3,101		0
3,110	3,110 PHYSICAL	(1,015,713)
3,111		0
3,112	3,112 PHYSICAL	0
3,113	3,113 PHYSICAL	0
3,140	3,140 LABORATORY INCOME	
3,150		0
3,151		
3,152	3,152 ST/OT THI	0
3,153	3,153 ST/OT THI	0
3,160	3,185 REHAB/ISOLATION/OTHER CHG	
3,410	3,410 IPA/OTHEI	0
3,411	3,411 MEDICARI	0
3,420	3,420 MEDICARI	1,079,430
3,452	3,452 HHS STIM	(376,056)
3,520	3,520 RENT INC	0
3,530	3,530 BEAUTY S	(5,404)
3,560	CONTRIBU	(197)
3,570	3,570 VENDING	0
3,590	3,590 EQUIPMEI	0
3,595	3,595 RESIDENT	0
3,600	3,600 MISC INC	(26)
4,110	4,110 G&A WAG	132,818
4,111	4,111 ADMINISTI	86,416
4,115	4,115 G&A PTO	19,229
4,120	4,120 EMPLOYE	41,173
4,121		0
4,130	4,130 EMPLOYE	0
4,135	4,135 EMPLOYE	0
4,250	4,250 OFFICE S	4,309
4,255	4,255 POSTAGE	2,285
4,260	4,260 TELEPHO	10,005
4,275	4,275 TRAINING	91
4,276		0
4,280	4,280 GENERAL	970
4,281	4,281 MEAL EXP	0
4,285	4,285 EDUCATIC	550
4,289	4,289 MEETINGS	0
4,290	4,290 HELP WAI	3,911
4,291	4,291 PROMOTI	3,299
4,292	4,292 PUBLIC RI	2,147
4,300	4,300 LICENSE &	55,557
4,310	4,310 DUES & S	7,332
4,320	4,320 CONTRIBU	0
4,350	4,350 PROFESS	5,327
4,355	4,355 MEDICAL I	24,000
4,362		1,015
4,363		4,767
4,364	4,364 SOCIAL SI	1,927
4,370	4,370 TV RENTA	13,868
4,383	4,383 BACKGRC	1,273
4,390	4,390 OTHER T/	0
4,400	4,400 PAYROLL	193,500
4,401	4,401 PAYROLL	0
4,410	4,410 GROUP IN	167,470
4,420	4,420 LIABILITY I	53,589
4,430	4,430 WORKMAI	21,803
4,435	4,435 W/C-FIRS	0
4,436	4,436 DRUG TES	1,650
4,450	4,450 MANAGEM	250,848
4,460	4,460 BAD DEBT	77,283
4,461	4,461 BAD DEBT	36,399
4,470	4,470 LOST ITEI	0
4,475	4,475 UNIFORM	(28)
4,486	4,486 SERVICE	65,091
4,490	4,490 MISC EXPI	129
4,496	4,496 MISC. M.I.S	11,037
4,510	4,510 REAL EST	0
4,600	4,600 LEASED E	14,992
5,110	5,110 MAINTENA	67,161
5,120	5,120 MAINTENA	4,267
5,130	5,130 ELECTRIC	40,972
5,131	5,131 NATURAL	17,019
5,133	5,133 WATER &	24,874
5,134	5,134 TRASH CC	5,457
5,140	5,140 PROP/PL/	1,413
5,160	5,160 GENERAL	26,549
5,165	5,165 MAINTENA	20,491
5,210	5,210 DIETARY	187,892
5,220	5,220 DIETARY	15,271
5,248	5,248 FOOD PU	181,316
5,250	5,250 SUPPLIES	1,226
5,260	5,260 REPLACE	1,013
5,270	5,270 KITCHEN	11,752
5,295	5,295 MEAL INC	(2,131)
5,310	5,310 LAUNDRY	38,949
5,340	5,340 LAUNDRY	1,602
5,370	5,370 REPLACE	9,738
5,230	5,230 DIETARY	6,126
5,390	5,390 LAUNDRY	8,108
5,410	5,410 HOUSEKE	98,720
5,440	5,440 HOUSEKE	10,404
5,480	5,480 SUPPLIES	29,531
5,490	5,490 SUPPLIES	0
6,020	6,020 RN WAGE	222,015
6,030	6,030 DON WAG	86,576
6,035	6,035 ADON WA	59,709
6,040	6,040 RN PTO &	12,159
6,120	6,120 LPN WAGI	367,279
6,140	6,140 LPN PTO	25,541
6,220	6,220 AIDES WA	868,799
6,240	6,240 AIDES PT	71,455
6,245	RN CONT	0
6,246	LPN CONT	0
6,247	AIDES CO	0
6,250		1,342
6,255		0
6,260		0
6,270	6,270 REHAB W	59,071
6,275	6,275 REHAB PT	4,732
6,290	6,290 NURSING	15,940
6,295	6,295 NURSING	99,974
6,390	6,390 REPLACE	5,054
6,490	6,490 OTHER	241
7,280	7,280 DRUG PU	137,537
7,281	7,281 DRUG PU	0
7,380	7,380 LABORAT	11,927
7,391	7,390 X-RAY SE	5,115
7,393		3,110
7,510	7,510 ACTIVITIE	42,512
7,540	7,540 ACTIVITIE	1,598
7,590	7,590 ACTIVITIE	854
7,620	7,620 PHYSICAL	166,082
7,660	7,660 P.T. SUPP	146
7,710	7,710 SOCIAL SI	42,168
7,720	7,720 SOCIAL SI	4,232
7,730	7,730 SOCIAL SI	0
7,740	7,740 OCCUPAT	121,414
7,750		0
7,770	7,770 SPEECH T	60,663
7,820	7,820 BEAUTICI	6,260
7,890		201
7,960		0
8,120	8,120 INTEREST	0
8,125		44,699
8,130	8,130 DEPRECI	0
8,150		0
9,510	9,510 INTEREST	(2,762)
9,520	9,520 MISC NON	0
9,530	4,220	0
	8,100	446,760
	9,702	0
	5,230	0
		(14,476)

Expenses Fixed Assets
0

Heritage Manor - Litchfield
IDPH ID# 48900
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	$	137,537
Purchased Hospital Services		3,315
Purchased Laboratory Services		11,927
Purchased Radiology Services		4,910
Amount Reclassified to Line 39	$	157,689

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

Line Item		
Provider Participation Fee - $1.50	$	(50,508)
Provider Assesment Fee - $6.07		(124,441)
	$	(174,949)
Provider Participation Fee	$	174,949

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

Line Item		
Pharmacy Consulting Fees	$	4,767