

		FOR BHF USE					

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

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

<p><b>I. IDPH License ID Number:</b> <u>0048108</u></p> <p><b>Facility Name:</b> <u>Heritage Health Mendota</u></p> <p><b>Address:</b> <u>1201 First Avenue</u> <u>Mendota</u> <u>61342</u>        Number City Zip Code</p> <p><b>County:</b> <u>LaSalle</u></p> <p><b>Telephone Number:</b> <u>( 815 ) 539-6745</u> Fax # ( )</p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>July 2007</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input checked="" type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>David M Underwood</u> <b>Telephone Number:</b> <u>(309)8237135</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;">(Type or Print Name) <u>David M Underwood</u></td> <td style="padding: 5px;">(Title) <u>EVP &amp; CFO</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 5px;">(Print Name and Title)</td> <td style="padding: 5px;">_____</td> </tr> <tr> <td style="padding: 5px;">(Firm Name &amp; Address)</td> <td style="padding: 5px;">_____</td> </tr> <tr> <td style="padding: 5px;">(Telephone)</td> <td style="padding: 5px;">( ) Fax # ( )</td> </tr> </table> <p align="right"><b>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</b></p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____	(Type or Print Name) <u>David M Underwood</u>	(Title) <u>EVP &amp; CFO</u>	Paid Preparer	(Signed) _____ (Date) _____	(Print Name and Title)	_____	(Firm Name & Address)	_____	(Telephone)	( ) Fax # ( )
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____														
Officer or Administrator of Provider	(Signed) _____ (Date) _____															
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Paid Preparer	(Signed) _____ (Date) _____															
(Print Name and Title)	_____															
(Firm Name & Address)	_____															
(Telephone)	( ) Fax # ( )															

Facility Name & ID Number Heritage Health Mendota

# 0048108 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	85	Skilled (SNF)	85	31,110	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	85	TOTALS	85	31,110	7

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,567	7,990	2,608	23,165	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,567	7,990	2,608	23,165	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.46%**

**D. How many bed reserve days during this year were paid by the Department?**  
None (Do not include bed reserve days in Section B.)

**E. List all services provided by your facility for non-patients.**  
(E.g., day care, "meals on wheels", outpatient therapy)  
None

**F. Does the facility maintain a daily midnight census?** Yes

**G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?**  
YES  NO

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

**I. On what date did you start providing long term care at this location?**  
Date started July 2007

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

**K. Was the facility certified for Medicare during the reporting year?**  
YES  NO  If YES, enter number of beds certified 85 and days of care provided 2,608

Medicare Intermediary WPS

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: \_\_\_\_\_ Fiscal Year: \_\_\_\_\_

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

Facility Name & ID Number Heritage Health Mendota # 0048108 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	201,472	18,655	6,203	226,330		226,330	4,147	230,477		1
2	Food Purchase		200,127		200,127		200,127	(14)	200,113		2
3	Housekeeping	74,133	25,829		99,962		99,962	5,529	105,491		3
4	Laundry	71,361	14,116		85,477		85,477	395	85,872		4
5	Heat and Other Utilities			73,866	73,866		73,866	1,316	75,182		5
6	Maintenance	80,429	58,863	91,321	230,613		230,613	16,135	246,748		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	427,395	317,590	171,390	916,375		916,375	27,508	943,883		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,039	12,039		12,039		12,039		9
10	Nursing and Medical Records	2,269,612	162,497	58,814	2,490,923	(4,872)	2,486,051	1,757	2,487,808		10
10a	Therapy		146,232	33,877	180,109	(175,237)	4,872		4,872		10a
11	Activities	87,453	541		87,994		87,994	4	87,998		11
12	Social Services	41,816		5,928	47,744		47,744	119	47,863		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,398,881	309,270	110,658	2,818,809	(180,109)	2,638,700	1,880	2,640,580		16
	<b>C. General Administration</b>										
17	Administrative	100,504			100,504		100,504		100,504		17
18	Directors Fees										18
19	Professional Services			326,740	326,740		326,740	(309,734)	17,006		19
20	Dues, Fees, Subscriptions & Promotions			201,440	201,440	(179,944)	21,496	(9,863)	11,633		20
21	Clerical & General Office Expenses	221,192	23,286	8,967	253,445		253,445	353,823	607,268		21
22	Employee Benefits & Payroll Taxes			541,465	541,465		541,465	35,632	577,097		22
23	Inservice Training & Education			36	36		36	1,085	1,121		23
24	Travel and Seminar			1,686	1,686		1,686	3,313	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			47,874	47,874		47,874	59,028	106,902		26
27	Other (specify):* <b>Lost resident items</b>			79,095	79,095		79,095	(79,095)			27
28	<b>TOTAL General Administration</b>	321,696	23,286	1,207,303	1,552,285	(179,944)	1,372,341	54,189	1,426,530		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,147,972	650,146	1,489,351	5,287,469	(360,053)	4,927,416	83,577	5,010,993		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 &amp; ID Number

Heritage Health Mendota

#0048108

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation							132,178	132,178			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			41,297	41,297		41,297	49,324	90,621			32
33	Real Estate Taxes							48,585	48,585			33
34	Rent-Facility & Grounds			435,420	435,420		435,420	(427,479)	7,941			34
35	Rent-Equipment & Vehicles			22,814	22,814		22,814	10,871	33,685			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			499,531	499,531		499,531	(186,521)	313,010			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			578,365	578,365	180,109	758,474	162,749	921,223			39
40	Barber and Beauty Shops			2,850	2,850		2,850		2,850			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					179,944	179,944		179,944			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			581,215	581,215	360,053	941,268	162,749	1,104,017			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,147,972	650,146	2,570,097	6,368,215		6,368,215	59,805	6,428,020			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,834)			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	(3,945)			17
18	Fines and Penalties				18
19	Entertainment	(1,112)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(15,398)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(79,095)			24
25	Fund Raising, Advertising and Promotional	(6,734)			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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (108,118)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	167,923		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 167,923		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 59,805		37

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

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

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

BHF USE ONLY							
48		49		50		51	
							52

Heritage Health Mendota

ID# 0048108

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		(15,398)	19	11
12		(1,834)	32	12
13		(79,095)	27	13
14		(6,734)	20	14
15		(3,945)	20	15
16		0	34	16
17		(1,112)	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	<b>Total</b>	(108,118)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Mendota# 0048108

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	4,147	0	0	0	0	0	0	0	0	4,147	1
2	Food Purchase	0	0	(14)	0	0	0	0	0	0	0	0	(14)	2
3	Housekeeping	0	0	5,529	0	0	0	0	0	0	0	0	5,529	3
4	Laundry	0	0	395	0	0	0	0	0	0	0	0	395	4
5	Heat and Other Utilities	0	0	1,316	0	0	0	0	0	0	0	0	1,316	5
6	Maintenance	0	0	16,135	0	0	0	0	0	0	0	0	16,135	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>27,508</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>27,508</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(19,719)	21,476	0	0	0	0	0	0	0	0	1,757	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	4	0	0	0	0	0	0	0	0	4	11
12	Social Services	0	0	119	0	0	0	0	0	0	0	0	119	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>(19,719)</b>	<b>21,599</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,880</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(15,398)	(308,413)	14,077	0	0	0	0	0	0	0	0	(309,734)	19
20	Fees, Subscriptions & Promotions	(10,679)	0	816	0	0	0	0	0	0	0	0	(9,863)	20
21	Clerical & General Office Expenses	0	0	353,823	0	0	0	0	0	0	0	0	353,823	21
22	Employee Benefits & Payroll Taxes	0	0	35,632	0	0	0	0	0	0	0	0	35,632	22
23	Inservice Training & Education	0	(36)	1,121	0	0	0	0	0	0	0	0	1,085	23
24	Travel and Seminar	(1,112)	0	4,425	0	0	0	0	0	0	0	0	3,313	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	59,028	0	0	0	0	0	0	0	0	59,028	26
27	Other (specify):*	(79,095)	0	0	0	0	0	0	0	0	0	0	(79,095)	27
28	<b>TOTAL General Administration</b>	<b>(106,284)</b>	<b>(308,449)</b>	<b>468,922</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>54,189</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(106,284)</b>	<b>(328,168)</b>	<b>518,029</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>83,577</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Mendota

# 0048108

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 (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	0	112,233	0	19,945	0	0	0	0	0	0	0	132,178	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,834)	48,919	0	2,239	0	0	0	0	0	0	0	49,324	32
33	Real Estate Taxes	0	48,585	0	0	0	0	0	0	0	0	0	48,585	33
34	Rent-Facility & Grounds	0	(433,620)	0	6,141	0	0	0	0	0	0	0	(427,479)	34
35	Rent-Equipment & Vehicles	0	0	0	10,871	0	0	0	0	0	0	0	10,871	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(1,834)</b>	<b>(223,883)</b>	<b>0</b>	<b>39,196</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(186,521)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	162,589	0	160	0	0	0	0	0	0	0	162,749	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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>162,589</b>	<b>0</b>	<b>160</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>162,749</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(108,118)</b>	<b>(389,462)</b>	<b>518,029</b>	<b>39,356</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>59,805</b>	<b>45</b>



**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Monroe SNF Services LLC	100	Attached Following This Page		Heritage Operations G	Bloomington	Mgmt. Services
				Green Tree Pharmacy	Minonk	Pharmacy
				Heritage Manor Real E	Bloomington	Propert rental

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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)	
1	V	10 Adjustment for Related Organiza	\$	GreenTree Pharmacy		\$ (19,719)	\$ (19,719)	1
2	V	23 Adjustment for Related Organization		GreenTree Pharmacy		(36)	(36)	2
3	V	39 Adjustment for Related Organization		GreenTree Pharmacy		162,589	162,589	3
4	V	19 Adjustment for Related Organization	308,413	Heritage Operations Group, LLC			(308,413)	4
5	V							5
6	V	34 Adjustment for Related Organization	433,620	Heritage Manor Real Estate, LLC			(433,620)	6
7	V	33 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		48,585	48,585	7
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		46,142	46,142	8
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		112,233	112,233	9
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		2,777	2,777	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 742,033			\$ 352,571	\$ * (389,462)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Heritage Operations Group		\$ 4,147	\$ 4,147
16	V	2 Food Purchase		Heritage Operations Group		(14)	(14)
17	V	3 Housekeeping		Heritage Operations Group		5,529	5,529
18	V	4 Laundry		Heritage Operations Group		395	395
19	V	5 Heat & Other Utilities		Heritage Operations Group		1,316	1,316
20	V	6 Maintenance		Heritage Operations Group		16,135	16,135
21	V	7 Other		Heritage Operations Group		0	
22	V	9 Medical Director		Heritage Operations Group		0	
23	V	10 Nursing & Medical Records		Heritage Operations Group		21,476	21,476
24	V	11 Activities		Heritage Operations Group		4	4
25	V	12 Social Service		Heritage Operations Group		119	119
26	V	13 Nurse Aide Training		Heritage Operations Group		0	
27	V	14 Program Transportation		Heritage Operations Group		0	
28	V	15 Other		Heritage Operations Group		0	
29	V	17 Administrative		Heritage Operations Group		0	
30	V	18 Directors Fees		Heritage Operations Group		0	
31	V	19 Professional Services		Heritage Operations Group		14,077	14,077
32	V	20 Fees, Subscription, Promotions		Heritage Operations Group		816	816
33	V	21 Clerical & General Office Expenses		Heritage Operations Group		353,823	353,823
34	V	22 Employee Benefits & Payroll Taxes		Heritage Operations Group		35,632	35,632
35	V	23 Inservice Training & Education		Heritage Operations Group		1,121	1,121
36	V	24 Travel and Seminar		Heritage Operations Group		4,425	4,425
37	V	25 Other Admin. Staff Transportation		Heritage Operations Group		0	
38	V	26 Insurance-Prop.Liab.Malpract		Heritage Operations Group		59,028	59,028
39	Total		\$			\$ 518,029	\$ * 518,029

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	27	\$	Heritage Operations Group		\$ 0	\$	15	
16	V	30		Heritage Operations Group		19,945	19,945	16	
17	V	31		Heritage Operations Group		0		17	
18	V	32		Heritage Operations Group		2,239	2,239	18	
19	V	33		Heritage Operations Group		0		19	
20	V	34		Heritage Operations Group		6,141	6,141	20	
21	V	35		Heritage Operations Group		10,871	10,871	21	
22	V	36		Heritage Operations Group		0		22	
23	V	38		Heritage Operations Group		0		23	
24	V	39		Heritage Operations Group		160	160	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		\$			\$ 39,356	\$ *	39,356	39

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

Facility Name & ID Number Heritage Health Mendota # 0048108 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	Monroe SNF Services LLC			100.00	0	0			\$ 0	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Heritage Health Mendota

# 0048108

Report Period Beginning:

1/1/2020

Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Heritage Operations Group

Street Address

115 W Jefferson Street

City / State / Zip Code

Bloomington, IL 61701

Phone Number

( 309 828-4361

Fax Number

( 309 829-5477

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,493	25	\$ 121,634	\$ 121,338	85	\$ 4,147	1
2	2	Food Purchase	Beds	2,493	25	(423)	0	85	(14)	2
3	3	Housekeeping	Beds	2,493	25	162,156	0	85	5,529	3
4	4	Laundry	Beds	2,493	25	11,591	0	85	395	4
5	5	Heat & Other Utilities	Beds	2,493	25	38,605	0	85	1,316	5
6	6	Maintenance	Beds	2,493	25	473,233	88,567	85	16,135	6
7	7	Other	Beds	2,493	25	0	0	85	0	7
8	9	Medical Director	Beds	2,493	25	0	0	85	0	8
9	10	Nursing & Medical Records	Beds	2,493	25	629,872	35,401	85	21,476	9
10	11	Activities	Beds	2,493	25	129	0	85	4	10
11	12	Social Service	Beds	2,493	25	3,478	3,478	85	119	11
12	13	Nurse Aide Training	Beds	2,493	25	0	0	85	0	12
13	14	Program Transportation	Beds	2,493	25	0	0	85	0	13
14	15	Other	Beds	2,493	25	0	0	85	0	14
15	17	Administrative	Beds	2,493	25	0	0	85	0	15
16	18	Directors Fees	Beds	2,493	25	0	0	85	0	16
17	19	Professional Services	Beds	2,493	25	412,869	0	85	14,077	17
18	20	Fees, Subscription, Promotions	Beds	2,493	25	23,945	0	85	816	18
19	21	Clerical & General Office Expense	Beds	2,493	25	10,377,428	9,978,005	85	353,823	19
20	22	Employee Benefits & Payroll Tax	Beds	2,493	25	1,045,059	0	85	35,632	20
21	23	Inservice Training & Education	Beds	2,493	25	32,865	0	85	1,121	21
22	24	Travel and Seminar	Beds	2,493	25	129,776	0	85	4,425	22
23	25	Other Admin. Staff Transportatio	Beds	2,493	25	0	0	85	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,493	25	1,731,253	0	85	59,028	24
25	TOTALS					\$ 15,193,470	\$ 10,226,789		\$ 518,029	25

Facility Name & ID Number Heritage Health Mendota

# 0048108

Report Period Beginning:

1/1/2020

Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Heritage Operations Group

Street Address

115 W Jefferson Street

City / State / Zip Code

Bloomington, IL 61701

Phone Number

( 309 828-4361

Fax Number

( 309 829-5477

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	27	Other	Beds	2,493	25	\$	\$	85	\$	1
2	30	Depreciation	Beds	2,493	25	584,981	85	19,945		2
3	31	Amortization of Pre-Op & Org	Beds	2,493	25		85			3
4	32	Interest	Beds	2,493	25	65,658	85	2,239		4
5	33	Real Estate Taxes	Beds	2,493	25		85			5
6	34	Rent-Facility & Grounds	Beds	2,493	25	180,106	85	6,141		6
7	35	Rent-Equipment & Vehicles	Beds	2,493	25	318,843	85	10,871		7
8	36	Other	Beds	2,493	25		85			8
9	38	Medically Nec Transportation	Beds	2,493	25		85			9
10	39	Ancillary Service Centers	Beds	2,493	25	4,685	85	160		10
11	40	Barber and Beauty Shops	Beds	2,493	25		85			11
12	41	Coffee and Gift Shops	Beds	2,493	25		85			12
13	42	Other	Beds	2,493	25		85			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	\$		\$ 39,356	25

Facility Name & ID Number

Heritage Health Mendota

# 0048108

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Busey Bank		xx	Mortgage			\$	\$			\$	46,142						
2	Busey Bank		xx	Loan Fee Amortization								2,777						
3																		
4																		
5																		
<b>Working Capital</b>																		
6	Busey Bank		xx	Working Capital								41,297						
7																		
8																		
9	<b>TOTAL Facility Related</b>						\$	\$			\$	90,216						
<b>B. Non-Facility Related*</b>																		
10	Interest Income											(1,834)						
11																		
12	Allocated Corporate											2,239						
13																		
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	405						
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$	90,621						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ None                      Line #                     

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2019 report.		\$		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.)		\$	<b>48,585</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>48,585</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>48,585</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2015	<b>51,857</b>	8	
	2016	<b>51,614</b>	9	
	2017	<b>51,147</b>	10	
	2018	<b>49,846</b>	11	
	2019	<b>48,585</b>	12	
				<b>FOR BHF USE ONLY</b>
	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 Mendota COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0048108

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE (      ) \_\_\_\_\_ FAX #: (      ) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>0134100020</u>	_____	\$ <u>48,584.90</u>	\$ <u>48,585.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>48,584.90</u></u>	\$ <u><u>48,585.00</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?      YES xx NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

**PLEASE NOTE: Payment information from the Internet or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.**

Facility Name & ID Number Heritage Health Mendota

# 0048108

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,580 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an empty column. Row 1: 1, 26,150, 1. Row 2: 2, 2. Row 3: 3 TOTALS, 26,150, 3.

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	85	1980	1965	\$ 697,500	\$		\$	\$	\$
5		1985	1985	408,657					
6									
7									
8									
<b>Improvement Type**</b>									
9									
10	1980 Improvements		1980	8,150					
11	1981 Improvements		1981	20,492					
12	1982 Improvements		1982	9,185					
13	1983 Improvements		1983	5,682					
14	1984 Improvements		1984	11,488					
15	1985 Improvements		1985	7,710					
16	1986 Improvements		1986	2,255					
17	1987 Improvements		1987	9,037					
18	1988 Improvements		1988	21,297					
19	1989 Improvements		1989	4,653					
20	1990 Improvements		1990	36,595					
21	1991 Improvements		1991						
22	1992 Improvements		1992	10,646					
23	1993 Improvements		1993	40,167					
24	1994 Improvements		1994	10,869					
25	1995 Improvements		1995	12,752					
26	1996 Improvements		1996	19,498					
27	1997 Improvements		1997	44,321					
28	1998 Improvements		1998	11,771					
29	1999 Improvements		1999	17,270					
30	2000 Improvements		2000	391,392					
31									
32									
33									
34	C/O Allocation				19,945		19,945		
35	Book Depreciation				87,064		87,064		
36									

\*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	2001 Improvements	2001	\$ 4,299	\$		\$	\$	37
38	2002 Improvements	2002	4,493					38
39	2003 Improvements	2003	6,927					39
40	2004 Improvements	2004	13,137					40
41	2005 Improvements	2005	90,752					41
42	2006 Improvements	2006	179,140					42
43	2007 Improvements	2007	216,052					43
44	2008 Improvements	2008	2,713					44
45	2009 Improvements	2009	46,518					45
46	2010 Improvements	2010	27,310					46
47	2011 Improvements	2011	3,513					47
48	2012 Improvements	2012	14,174					48
49	2013 Improvements	2013	15,794					49
50	2014 Improvements	2014	20,245					50
51								51
52	Installed (5) PTAC units							52
53								53
54	Install 100AMP emergency panel for dining room	2015	3,321					54
55	Install new shower room floor and attach new water lines							55
56		2016	4,500					56
57	Install HVAC unit	2016	13,884					57
58	Repalce water heater							58
59		2017	11,860					59
60		2017	6,656					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)		\$ 2,486,675	\$ 107,009		\$ 107,009	\$	70

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12A, Carried Forward</b>								
2		\$ 2,486,675	\$ 107,009		\$ 107,009				1
3	2018	2,641							2
4									3
5	2019	2,777							4
6	2019	289,852							5
7	Remodeling Project:								
8	Phase 1 - New flooring, millwork base, paint, lighting and window treatments in front entry area. Salon, administrator office care planning room, front entry nursing station and living room.								
9									6
10									7
11	Phase 2 - For 30 bathrooms provided new paint, ceiling tile, flooring, base sinks&vanity tops, toilets, wall protection, new lighting and new mirrors/cabinets, faucets, towel dispensers and grab bars								
12									8
13									9
14									10
15	2020	4,761							11
16	2020	3,962							12
17									13
18									14
19									15
20									16
21									17
22									18
23									19
24									20
25									21
26									22
27									23
28									24
29									25
30									26
31									27
32									28
33									29
34	<b>TOTAL (lines 1 thru 33)</b>								
		\$ 2,790,668	\$ 107,009		\$ 107,009				30
									31
									32
									33
									34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,146,268	\$ 25,169	\$ 25,169	\$		\$	71
72	Current Year Purchases	24,246						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,170,514	\$ 25,169	\$ 25,169	\$		\$	75

D. Vehicle Costs. (See instructions.)\*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,987,332	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 132,178	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 132,178	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 Mendota

# 0048108

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	<b>TOTAL</b>				\$			7

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	\$ _____

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 22,814 Description: Televisions and copiers

(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	<b>TOTAL</b>		\$	\$	21

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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)	
<b>TOTAL TRAINED</b>	

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

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



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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 225,801	\$		\$ 225,801	1
2	Licensed Speech and Language Development Therapist		hrs			101,277			101,277	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			251,287	0		251,287	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				146,232		146,232	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____					33,877			33,877	13
14	TOTAL			\$		\$ 612,242	\$ 146,232		\$ 758,474	14

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

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/2020**

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 404	\$	1
2	Cash-Patient Deposits	18,851		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	313,924		3
4	Supply Inventory (priced at <u>FIFO</u> )	28,826		4
5	Short-Term Investments			5
6	Prepaid Insurance	734		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(687,162)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (324,423)	\$	10
	<b>B. Long-Term Assets</b>			
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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ (324,423)	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,851		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	277,217		30
31	Accrued Taxes Payable (excluding real estate taxes)	911		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
	<b>Other Current Liabilities(specify):</b>			
36	<u>Bed Tax</u>	6,434		36
37	<u>Deferred Stimulus</u>	205,451		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 508,864	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 508,864	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (833,287)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ (324,423)	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(847,542)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(847,542)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>14,255</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>14,255</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(833,287)</b>	<b>24</b> *

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

Facility Name &amp; ID Number Heritage Health Mendota

# 0048108

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.**

1

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,632,843	1
2	Discounts and Allowances for all Levels	(1,610,009)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,022,834	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,750,158	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,750,158	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants	364,759	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,287	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	235,875	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	868	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 605,789	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	1,855	24
25	Interest and Other Investment Income***	1,834	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,689	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,382,470	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	916,375	31
32	Health Care	2,818,809	32
33	General Administration	1,552,285	33
<b>B. Capital Expense</b>			
34	Ownership	499,531	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	581,215	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,368,215	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	14,255	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 14,255	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	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$	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 Mendota

# 0048108

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	1,973	2,055	\$ 88,055	\$ 42.85	1
2	Assistant Director of Nursing	1,904	1,983	64,945	32.75	2
3	Registered Nurses	15,827	16,486	571,855	34.69	3
4	Licensed Practical Nurses	11,693	12,180	362,449	29.76	4
5	CNAs & Orderlies	66,173	68,930	1,182,308	17.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,507	6,778	87,453	12.90	10
11	Social Service Workers	1,846	1,923	41,816	21.75	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,677	16,330	201,472	12.34	15
16	Dishwashers					16
17	Maintenance Workers	3,787	3,945	80,429	20.39	17
18	Housekeepers	5,227	5,445	74,133	13.61	18
19	Laundry	5,418	5,644	71,361	12.64	19
20	Administrator	1,961	2,043	100,504	49.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,352	8,700	221,192	25.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	146,345	152,442	\$ 3,147,972 *	\$ 20.65	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	\$ 6,203	L1 C3	35
36	Medical Director	12,039	L9 C3	36
37	Medical Records Consultant	493	L10 C3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	4,872	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	5,928	L12 C3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 29,535		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 17,500	L10 C3	50
51	Licensed Practical Nurses	20,806	L10 C3	51
52	Certified Nurse Assistants/Aides	15,143	L10 C3	52
53	TOTAL (lines 50 - 52)	\$ 53,449		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Michelle Hansen	Administrator		\$ 100,504	Workers' Compensation Insurance	\$ 21,103	IDPH License Fee	\$	
				Unemployment Compensation Insurance	6,358	Advertising: Employee Recruitment	3,209	
				FICA Taxes	240,820	Health Care Worker Background Check (Indicate # of checks performed )	1,772	
				Employee Health Insurance	187,008	Patient Background Checks		
				Employee Meals		PR	1,439	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	6,920	
						License & Fees	2,861	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 100,504	Other Benefits	86,176	Central Office Allocation	816	
				Central Office Allocation	35,632	Less: Public Relations Expense	(1,439)	
B. Administrative - Other						Non-allowable advertising	(3,945)	
Description			Amount			Yellow page advertising (		
			\$					
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 11,633	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 577,097			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount			\$	Out-of-State Travel	\$
Heritage Operations Group	Management		\$ 311,342					
							In-State Travel	
								1,360
								76
							Seminar Expense	250
								3,313
							Entertainment Expense (	
Legal adj to Zero			15,398				(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 326,740	TOTAL		\$	TOTAL	\$ 4,999

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name &amp; ID Number Heritage Health Mendota

# 0048108

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 - \$5,950
- (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. \$ 179,944  
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. \$ 492
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100%  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? NA  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: MCK CPA's & Advisors
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. None Claimed  
Attach invoices and a summary of services for all architect and appraisal fees.





Heritage Manor - Mendota  
IDPH ID# 48108  
HFS Cost Report - December 31, 2020  
Schedule V - Column 5 Reclassifications

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

<u>Line Item</u>		
Purchased Drugs and Medications	\$	146,232
Purchased Hospital Services		5,878
Purchased Laboratory Services		25,003
Purchased Radiology Services		2,996
Amount Reclassified to Line 39	\$	<u>180,109</u>

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

<u>Line Item</u>		
Provider Participation Fee - \$1.50	\$	(46,665)
Provider Assesment Fee - \$6.07		<u>(133,279)</u>
	\$	<u>(179,944)</u>
Provider Participation Fee	\$	<u>179,944</u>

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

<u>Line Item</u>		
Pharmacy Consultant Fees	\$	<u>4,872</u>