		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: 0048082

Facility Name: Heritage Health Normal

Address: 509 N Adelaide (Number) Normal (City) 61761 (Zip Code)

County: McLean

Telephone Number: (309) 452-7468 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: July 2006

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider

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

Paid Preparer

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

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

Facility Name & ID Number Heritage Health Normal # 0048082 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	141	Skilled (SNF)	141	51,606	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	141	TOTALS	141	51,606	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	22,013	16,144	2,078	40,235	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,013	16,144	2,078	40,235	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.97%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started July 2006

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

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified 141 and days of care provided 2,078

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 Normal # 0048082 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	537,466	49,365	7,920	594,751		594,751	6,879	601,630			1
2	Food Purchase		314,291		314,291		314,291	(24)	314,267			2
3	Housekeeping	264,143	46,923		311,066		311,066	9,171	320,237			3
4	Laundry	102,924	26,429		129,353		129,353	656	130,009			4
5	Heat and Other Utilities			121,886	121,886		121,886	2,183	124,069			5
6	Maintenance	109,075	73,123	187,703	369,901		369,901	26,765	396,666			6
7	Other (specify):*											7
8	TOTAL General Services	1,013,608	510,131	317,509	1,841,248		1,841,248	45,630	1,886,878			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	3,592,154	265,735	1,046,102	4,903,991	(9,149)	4,894,842	11,052	4,905,894			10
10a	Therapy		261,528	38,391	299,919	(290,190)	9,729		9,729			10a
11	Activities	127,489	6,039		133,528		133,528	7	133,535			11
12	Social Services	127,860		2,594	130,454		130,454	197	130,651			12
13	CNA Training	6,695	5,538		12,233		12,233		12,233			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,854,198	538,840	1,101,487	5,494,525	(299,339)	5,195,186	11,256	5,206,442			16
	C. General Administration											
17	Administrative	94,157			94,157		94,157		94,157			17
18	Directors Fees											18
19	Professional Services			545,367	545,367		545,367	(516,830)	28,537			19
20	Dues, Fees, Subscriptions & Promotions			375,545	375,545	(318,315)	57,230	(21,855)	35,375			20
21	Clerical & General Office Expenses	518,898	38,575	14,324	571,797		571,797	586,930	1,158,727			21
22	Employee Benefits & Payroll Taxes			1,068,165	1,068,165		1,068,165	59,107	1,127,272			22
23	Inservice Training & Education			195	195		195	1,787	1,982			23
24	Travel and Seminar			4,756	4,756		4,756	243	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			82,563	82,563		82,563	97,917	180,480			26
27	Other (specify):*			120,968	120,968		120,968	(120,968)				27
28	TOTAL General Administration	613,055	38,575	2,211,883	2,863,513	(318,315)	2,545,198	86,331	2,631,529			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,480,861	1,087,546	3,630,879	10,199,286	(617,654)	9,581,632	143,217	9,724,849			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 Normal #0048082 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation							509,746	509,746			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			69,993	69,993		69,993	120,711	190,704			32
33	Real Estate Taxes							113,147	113,147			33
34	Rent-Facility & Grounds			718,320	718,320		718,320	(708,133)	10,187			34
35	Rent-Equipment & Vehicles			84,154	84,154		84,154	18,033	102,187			35
36	Other (specify):*											36
37	**TOTAL Ownership**			872,467	872,467		872,467	53,504	925,971			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			662,096	662,096	299,339	961,435	410,285	1,371,720			39
40	Barber and Beauty Shops		96	6,025	6,121		6,121		6,121			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					318,315	318,315		318,315			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		96	668,121	668,217	617,654	1,285,871	410,285	1,696,156			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,480,861	1,087,642	5,171,467	11,739,970		11,739,970	607,006	12,346,976			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 Normal # 0048082 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	(810)			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	(6,906)			17
18	Fines and Penalties	(875)			18
19	Entertainment	(7,097)			19
20	Contributions	(10)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(21,688)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(120,083)			24
25	Fund Raising, Advertising and Promotional	(16,303)			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)**	$ (173,772)		$	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)	780,778		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 780,778		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 607,006		37

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

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

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

Heritage Health Normal

ID# 0048082

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		(21,688)	19	11
12		(810)	32	12
13		(120,083)	27	13
14		(16,303)	20	14
15		(10)	27	15
16		(875)	27	16
17		(7,097)	24	17
18		(6,906)	20	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	(173,772)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Normal # 0048082 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	6,879	0	0	0	0	0	0	0	0	6,879	1
2	Food Purchase	0	0	(24)	0	0	0	0	0	0	0	0	(24)	2
3	Housekeeping	0	0	9,171	0	0	0	0	0	0	0	0	9,171	3
4	Laundry	0	0	656	0	0	0	0	0	0	0	0	656	4
5	Heat and Other Utilities	0	0	2,183	0	0	0	0	0	0	0	0	2,183	5
6	Maintenance	0	0	26,765	0	0	0	0	0	0	0	0	26,765	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	45,630	0	0	0	0	0	0	0	0	45,630	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	(24,573)	35,625	0	0	0	0	0	0	0	0	11,052	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	7	0	0	0	0	0	0	0	0	7	11
12	Social Services	0	0	197	0	0	0	0	0	0	0	0	197	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	(24,573)	35,829	0	0	0	0	0	0	0	0	11,256	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	(21,688)	(518,493)	23,351	0	0	0	0	0	0	0	0	(516,830)	19
20	Fees, Subscriptions & Promotions	(23,209)	0	1,354	0	0	0	0	0	0	0	0	(21,855)	20
21	Clerical & General Office Expenses	0	0	586,930	0	0	0	0	0	0	0	0	586,930	21
22	Employee Benefits & Payroll Taxes	0	0	59,107	0	0	0	0	0	0	0	0	59,107	22
23	Inservice Training & Education	0	(72)	1,859	0	0	0	0	0	0	0	0	1,787	23
24	Travel and Seminar	(7,097)	0	7,340	0	0	0	0	0	0	0	0	243	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	97,917	0	0	0	0	0	0	0	0	97,917	26
27	Other (specify):*	(120,968)	0	0	0	0	0	0	0	0	0	0	(120,968)	27
28	**TOTAL General Administration**	(172,962)	(518,565)	777,858	0	0	0	0	0	0	0	0	86,331	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(172,962)	(543,138)	859,317	0	0	0	0	0	0	0	0	143,217	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Normal **#** 0048082 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	476,660	0	33,086	0	0	0	0	0	0	0	509,746	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(810)	117,807	0	3,714	0	0	0	0	0	0	0	120,711	32
33	Real Estate Taxes	0	113,147	0	0	0	0	0	0	0	0	0	113,147	33
34	Rent-Facility & Grounds	0	(718,320)	0	10,187	0	0	0	0	0	0	0	(708,133)	34
35	Rent-Equipment & Vehicles	0	0	0	18,033	0	0	0	0	0	0	0	18,033	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(810)	(10,706)	0	65,020	0	0	0	0	0	0	0	53,504	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	410,020	0	265	0	0	0	0	0	0	0	410,285	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	410,020	0	265	0	0	0	0	0	0	0	410,285	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(173,772)	(143,824)	859,317	65,285	0	0	0	0	0	0	0	607,006	45

Facility Name & ID Number Heritage Health Normal # 0048082 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
Center 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		$ (24,573)	$ (24,573)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy		(72)	(72)	2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy		410,020	410,020	3
4	V	19	Adjustment for Related Organization	518,493	Heritage Operations Group, LLC			(518,493)	4
5	V								5
6	V	34	Adjustment for Related Organization	718,320	Heritage Manor Real Estate, LLC			(718,320)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		113,147	113,147	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		110,004	110,004	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		476,660	476,660	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		7,803	7,803	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,236,813			$ 1,092,989	$ * (143,824)	14

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

Facility Name & ID Number Heritage Health Normal # 0048082 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Heritage Operations Group		$ 6,879	$ 6,879	15
16	V	2	Food Purchase		Heritage Operations Group		(24)	(24)	16
17	V	3	Housekeeping		Heritage Operations Group		9,171	9,171	17
18	V	4	Laundry		Heritage Operations Group		656	656	18
19	V	5	Heat & Other Utilities		Heritage Operations Group		2,183	2,183	19
20	V	6	Maintenance		Heritage Operations Group		26,765	26,765	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		35,625	35,625	23
24	V	11	Activities		Heritage Operations Group		7	7	24
25	V	12	Social Service		Heritage Operations Group		197	197	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		23,351	23,351	31
32	V	20	Fees, Subscription, Promotions		Heritage Operations Group		1,354	1,354	32
33	V	21	Clerical & General Office Expenses		Heritage Operations Group		586,930	586,930	33
34	V	22	Employee Benefits & Payroll Taxes		Heritage Operations Group		59,107	59,107	34
35	V	23	Inservice Training & Education		Heritage Operations Group		1,859	1,859	35
36	V	24	Travel and Seminar		Heritage Operations Group		7,340	7,340	36
37	V	25	Other Admin. Staff Transportation		Heritage Operations Group		0		37
38	V	26	Insurance-Prop.Liab.Malpract		Heritage Operations Group		97,917	97,917	38
39	Total			$			$ 859,317	$ * 859,317	39

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

Facility Name & ID Number Heritage Health Normal # 0048082 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	27		$	Heritage Operations Group		$	$ 0	15
16	V	30			Heritage Operations Group			33,086	16
17	V	31			Heritage Operations Group			0	17
18	V	32			Heritage Operations Group			3,714	18
19	V	33			Heritage Operations Group			0	19
20	V	34			Heritage Operations Group			10,187	20
21	V	35			Heritage Operations Group			18,033	21
22	V	36			Heritage Operations Group			0	22
23	V	38			Heritage Operations Group			0	23
24	V	39			Heritage Operations Group			265	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			$			$ 0	$ * 65,285	39

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

Facility Name & ID Number Heritage Health Normal # 0048082 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Center 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 Normal # 0048082 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	141	$ 6,879	1
2	2	Food Purchase	Beds	2,493	25	(423)	0	141	(24)	2
3	3	Housekeeping	Beds	2,493	25	162,156	0	141	9,171	3
4	4	Laundry	Beds	2,493	25	11,591	0	141	656	4
5	5	Heat & Other Utilities	Beds	2,493	25	38,605	0	141	2,183	5
6	6	Maintenance	Beds	2,493	25	473,233	88,567	141	26,765	6
7	7	Other	Beds	2,493	25	0	0	141	0	7
8	9	Medical Director	Beds	2,493	25	0	0	141	0	8
9	10	Nursing & Medical Records	Beds	2,493	25	629,872	35,401	141	35,625	9
10	11	Activities	Beds	2,493	25	129	0	141	7	10
11	12	Social Service	Beds	2,493	25	3,478	3,478	141	197	11
12	13	Nurse Aide Training	Beds	2,493	25	0	0	141	0	12
13	14	Program Transportation	Beds	2,493	25	0	0	141	0	13
14	15	Other	Beds	2,493	25	0	0	141	0	14
15	17	Administrative	Beds	2,493	25	0	0	141	0	15
16	18	Directors Fees	Beds	2,493	25	0	0	141	0	16
17	19	Professional Services	Beds	2,493	25	412,869	0	141	23,351	17
18	20	Fees, Subscription, Promotions	Beds	2,493	25	23,945	0	141	1,354	18
19	21	Clerical & General Office Expens	Beds	2,493	25	10,377,428	9,978,005	141	586,930	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,493	25	1,045,059	0	141	59,107	20
21	23	Inservice Training & Education	Beds	2,493	25	32,865	0	141	1,859	21
22	24	Travel and Seminar	Beds	2,493	25	129,776	0	141	7,340	22
23	25	Other Admin. Staff Transportatio	Beds	2,493	25	0	0	141	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,493	25	1,731,253	0	141	97,917	24
25	TOTALS					$ 15,193,470	$ 10,226,789		$ 859,317	25

Facility Name & ID Number Heritage Health Normal # 0048082 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	$	$	141	$	1
2	30	Depreciation	Beds	2,493	25	584,981		141	33,086	2
3	31	Amortization of Pre-Op & Org	Beds	2,493	25			141		3
4	32	Interest	Beds	2,493	25	65,658		141	3,714	4
5	33	Real Estate Taxes	Beds	2,493	25			141		5
6	34	Rent-Facility & Grounds	Beds	2,493	25	180,106		141	10,187	6
7	35	Rent-Equipment & Vehicles	Beds	2,493	25	318,843		141	18,033	7
8	36	Other	Beds	2,493	25			141		8
9	38	Medically Nec Transportation	Beds	2,493	25			141		9
10	39	Ancillary Service Centers	Beds	2,493	25	4,685		141	265	10
11	40	Barber and Beauty Shops	Beds	2,493	25			141		11
12	41	Coffee and Gift Shops	Beds	2,493	25			141		12
13	42	Other	Beds	2,493	25			141		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	$		$ 65,285	25

Facility Name & ID Number Heritage Health Normal # 0048082 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			$	$			$ 110,004	1
2	Busey Bank		xx	Loan Fee Amortization							7,803	2
3												3
4												4
5												5
	Working Capital											
6	Busey Bank		xx	Working Capital							69,993	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 187,800	9
	B. Non-Facility Related*											
10	Interest Income										(810)	10
11												11
12	Allocated Corporate										3,714	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 2,904	14
15	TOTALS (line 9+line14)						$	$			$ 190,704	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 Normal # 0048082 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	113,147	2
3. Under or (over) accrual (line 2 minus line 1).	$	113,147	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.	$	113,147	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2015	103,841	8
2016	106,738	9
2017	107,911	10
2018	111,900	11
2019	113,147	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Health Normal COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0048082

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.	14-29-227-016		$ 155,798.60	$ 113,147.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 155,798.60	$ 113,147.00

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? xx YES 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 Normal # 0048082 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,164 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).

Adelaide Apts - Independent Living - No shared services but real estate taxes shown on same bill

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$ 181,333	1
2					2
3	TOTALS			$ 181,333	3

Facility Name & ID Number Heritage Health Normal # 0048082 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	141				$ 1,860,193	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1979 Improvements			1979	66,917						9
10	1980 Improvements			1980	48,089						10
11	1981 Improvements			1981	17,747						11
12	1982 Improvements			1982	18,009						12
13	1983 Improvements			1983	19,892						13
14	1984 Improvements			1984	25,484						14
15	1985 Improvements			1985	531,851						15
16	1986 Improvements			1986	82,460						16
17	1987 Improvements			1987	17,447						17
18	1988 Improvements			1988	133,532						18
19	1989 Improvements			1989	39,555						19
20	1990 Improvements			1990	18,557						20
21	1991 Improvements			1991	5,776						21
22	1991 Improvements			1992	8,016						22
23	1993 Improvements			1993	188,048						23
24	1994 Improvements			1994	187,325						24
25	1995 Improvements			1995	10,664						25
26	1996 Improvements			1996	39,518						26
27	1997 Improvements			1997	25,427						27
28	1998 Improvements			1998	1,932,921						28
29	1999 Improvements			1999	2,108,304						29
30	2000 Improvements			2000	81,048						30
31	2001 Improvements			2001	30,418						31
32	2002 Improvements			2002	42,330						32
33											33
34	C/O Allocation					33,086		33,086			34
35	Book Depreciation					380,017		380,017			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 Normal # 0048082 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	2003 Improvements	2003	$ 38,044	$		$	$	$	37
38	2004 Improvements	2004	50,416						38
39	2005 Improvements	2005	28,379						39
40	2006 Improvements	2006	5,900						40
41	2007 Improvements	2007	35,899						41
42	2008 Improvements	2008	186,351						42
43	2009 Improvements	2009	472,220						43
44	2010 Improvements	2010	118,174						44
45	2011 Improvements	2011	429,238						45
46	2012 Improvements	2012	217,692						46
47	2013 Improvements	2013	771,088						47
48	2014 Improvements	2014	366,084						48
49									49
50	Retube boiler	2015	15,200						50
51	New flooring - soiled utility room	2015	6,472						51
52	Compressor replacement	2015	3,861						52
53	Replacement split system for laundry room	2015	6,725						53
54	Replaced failed LCD annunciator	2015	3,910						54
55									55
56	Install new air compressor	2016	3,082						56
57	Upgrade elevator - installation of new alarms, lights	2016	10,330						57
58	pit ladder and phone								58
59	EIFS repairs to front car port and north side of building	2016	7,850						59
60									60
61	Replace old boiler	2017	252,610						61
62	Remove and replace stairwell flooring	2017	8,567						62
63	Added data lines for new offices and for point of care	2017	6,589						63
64	clinical system								64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 10,584,209	$ 413,103		$ 413,103	$	$	70

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

Facility Name & ID Number Heritage Health Normal # 0048082 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 10,584,209	$ 413,103		$ 413,103	$	$	1
2									2
3	Replace water softener system	2018	8,379						3
4	Replace compressor - walk in cooler	2018	4,835						4
5	Replace roof top AC unit - East dining area	2018	14,665						5
6	New compressors - commons area	2018	5,401						6
7	Replace generator panel - RTU	2018	7,907						7
8	Replace hot water coil and air handler	2018	4,985						8
9									9
10	Remodeled (2) nurses stations - new cabinets, flooring,								10
11	and countertops; remediated asbestos; installed new electrical outl	2019	103,322						11
12	New cabling for wireless access locations	2019	8,958						12
13	Replace mixing valve	2019	2,925						13
14	Replace grease trap	2019	7,400						14
15	Install new fire hydrant	2019	3,500						15
16	Replace storm drain	2019	3,600						16
17	Replace air compressor - fire sprinkler system	2019	4,417						17
18	Install Bell & Gosset Pump - Legacy Unit	2019	3,125						18
19	Replace faulty hallway door	2019	2,593						19
20									20
21	Repair sprinkler system and adapt to new standards	2020	44,997						21
22	Install new 100 gallon water heater	2020	6,170						22
23	Replaced fire alarm system	2020	23,963						23
24	Replaced carpet - Legacy Unit	2020	14,230						24
25	Replaced HVAC-Main Hall Lounge	2020	7,615						25
26	Replaced Walk-In Freezer Door	2020	4,965						26
27	Replaced boiler system piping	2020	4,390						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,876,551	$ 413,103		$ 413,103	$	$	34

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

Facility Name & ID Number Heritage Health Normal # 0048082 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,254,649	$ 96,643	$ 96,643	$		$	71
72	Current Year Purchases	46,042						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,300,691	$ 96,643	$ 96,643	$		$	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)	$ 13,358,575	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 509,746	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 509,746	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 Normal # 0048082 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: $ 84,154 Description: Office equipment
(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 Normal # 0048082 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		5,538		5,538
3	Classroom Wages (a)				
4	Clinical Wages (b)		6,695		6,695
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 12,233	$	$ 12,233
10	SUM OF line 9, col. 1 and 2 (e)	$ 12,233			

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	$		$ 362,983	$		$ 362,983	1
2	Licensed Speech and Language Development Therapist		hrs			38,799			38,799	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			260,314	580		260,894	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				260,948		260,948	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					38,391			38,391	13
14	TOTAL			$		$ 700,487	$ 261,528		$ 962,015	14

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

STATE OF ILLINOIS

Facility Name & ID Number Heritage Health Normal # 0048082 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	$ 400	$	1
2	Cash-Patient Deposits	32,830		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	52,027		3
4	Supply Inventory (priced at FIFO)	18,784		4
5	Short-Term Investments			5
6	Prepaid Insurance	5,727		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,172,723)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (1,062,955)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ (1,062,955)	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,830		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	411,820		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,171		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	19,624		36
37	Deferred Stimulus	137,896		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 605,341	$	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)**	$ 605,341	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,668,296)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (1,062,955)	$	48

*(See instructions.)

Facility Name & ID Number Heritage Health Normal # 0048082 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**	$ (659,979)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (659,979)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,008,317)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,008,317)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,668,296)	24 *

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

Facility Name & ID Number Heritage Health Normal # 0048082 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	$ 9,715,095	1
2	Discounts and Allowances for all Levels	(1,753,470)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,961,625	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,703,020	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,703,020	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	694,570	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	7,096	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	365,236	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(704)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,066,198	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	810	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 810	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)**	$ 10,731,653	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,841,248	31
32	Health Care	5,494,525	32
33	General Administration	2,863,513	33
	B. Capital Expense		
34	Ownership	872,467	34
	C. Ancillary Expense		
35	Special Cost Centers	668,217	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)***	$ 11,739,970	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,008,317)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,008,317)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Heritage Health Normal # 0048082 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	987	1,029	$ 56,544	$ 54.95	1
2	Assistant Director of Nursing	3,430	3,573	109,112	30.54	2
3	Registered Nurses	15,007	15,632	613,564	39.25	3
4	Licensed Practical Nurses	32,762	34,127	1,049,172	30.74	4
5	CNAs & Orderlies	100,897	105,101	1,710,976	16.28	5
6	CNA Trainees	647	674	6,695	9.93	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,801	2,917	52,786	18.10	8
9	Activity Director					9
10	Activity Assistants	9,060	9,438	127,489	13.51	10
11	Social Service Workers	5,852	6,095	127,860	20.98	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	40,907	42,612	537,466	12.61	15
16	Dishwashers					16
17	Maintenance Workers	6,793	7,076	109,075	15.41	17
18	Housekeepers	22,376	23,309	264,143	11.33	18
19	Laundry	7,679	7,999	102,924	12.87	19
20	Administrator	2,020	2,104	94,157	44.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,813	21,681	518,898	23.93	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)	272,031	283,367	$ 5,480,861 *	$ 19.34	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 7,920	L1 C3	35
36	Medical Director		14,400	L9 C3	36
37	Medical Records Consultant		535	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		9,149	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		1,955	L12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 33,959		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 375,546	L10 C3	50
51	Licensed Practical Nurses		207,458	L10 C3	51
52	Certified Nurse Assistants/Aides		453,096	L10 C3	52
53	TOTAL (lines 50 - 52)		$ 1,036,100		53

Facility Name & ID Number Heritage Health Normal # 0048082 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tami Wacker	Administrator		$ 94,157
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 94,157

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	$ 523,679
Legal adj to Zero		21,688
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 545,367

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 53,436
Unemployment Compensation Insurance	25,792
FICA Taxes	419,286
Employee Health Insurance	319,167
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	250,484
Central Office Allocation	59,107
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,127,272

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	13,809
Health Care Worker Background Check	
(Indicate # of checks performed)	5,169
Patient Background Checks	
PR	6,645
Dues & Subscriptions	11,342
License & Fees	10,607
Central Office Allocation	1,354
Less: Public Relations Expense	(6,645)
Non-allowable advertising	(6,906)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,375

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	3,576
	0
Seminar Expense	1,180
	243
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,999

**See instructions.

Facility Name & ID Number Heritage Health Normal # 0048082 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 - $9,872**

(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. $ **318,315**
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. $ **29,139**

(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	400						
1010			CASH IN BANK							
1040			CASH IN BANK-PAYROLL							
1100			ACCOUNTS RECEIVABLE	52,027						
1110			MEDICARE RECEIVABLES							
1125			IPA INCOME RECEIVABLE							
1130			MEDICARE COST REPORT							
1132			US HHS STIMULUS SETTLEME	-137,896						
1140			UNAPPLIED CASH RECEIPTS							
1145			A/R SUSPENSE-REFUNDS							
1190			ACCRUED INTEREST REC							
1200			PREPAID INSURANCE	5,727						
1220			OTHER PREPAID EXPENSES							
1300			FOOD INVENTORY	18,784						
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	32,830						
1550			LOAN FEES	0						
1560			REAL ESTATE TAX ESCROW							
1575			REIMBURSABLE PURCHASES							
1850			INTRACOMPANY	-1,172,723						
2010			ACCOUNTS PAYABLE	0						
2095			BONUSES PAYABLE							
2100			ACCRUED PAYROLL	-202,987						
2110			ACCRUED VACATION PAY	-208,833						
2120			UC TAXES PAYABLE							
2125			FICA TAX PAYABLE	-3,171	-3,171					
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	-19,624						
2350			REAL ESTATE TAX PAYABLE	0						
2385			ACTIVITY FUND	0						
2390			SECURITY DEPOSITS	0						
2391			VOLUNTEER FUND							
2393			HEART FUND/BAZAAR							
2395			DEFERRED INC EMP & MEM							
2400			CURRENT PORTION LT DEBT							
2460			INCOME TAXES PAYABLE							
2512			DUE TO RESIDENTS	-32,830						
2600			MORTGAGE PAYABLE	0						
2650			EQUIPMENT LOAN PAYABLE							
2695			CURRENT PORTION LT DEBT							
2696			DEFERRED INCOME TAXES							
2710			COMMON STOCK							
2720			RETAINED EARNINGS	659,979						
2970			PROFIT/LOSS FOR PERIOD	1,008,317						
3007.1			PATIENT DAYS-PRIVATE	16,144						
3007.2			PATIENT DAYS-IPA	22,013						
3007.3			PATIENT DAYS-MEDICARE	2,078						
3007.4			PATIENT DAYS-CONVERSION							
3007.5			PATIENT DAYS-LICENSED							
3007.6			PATIENT DAYS-TOTAL							
3010		1	BASIC CHARGE-PRIVATE & VA	-9,713,599		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	-1,372		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	-365,236		0	0	0	0	
3101		17	DRUGS-OTHER							
3110		6	PT-PRIVATE	-1,703,020		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	240,906						
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	1,753,470		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	-694,570		42	3	0	0	
3520		16	RENT INCOME	0		6	0	6	0	
3530		13	BEAUTY SHOP	-7,096		0	0	0	0	
3560		12	ACTIVITY FUND INCOME	0		0	0	0	0	
3570		12	VENDING INCOME/EXPENSE	0		0	0	0	0	
3580		12	MANAGEMENT FEES			0	0	0	0	
3590		1	EQUIPMENT RENTAL	-124		0	0	0	0	
3595		21	RESIDENT TRANSPORTATION	0		0	0	0	0	
3600		21	MISC INCOME	704		0	0	0	0	
4110			GENERAL & ADMINIST WAGES	477,302	518,898	21	1	17	0	
4111			ADMINISTRATOR WAGES	94,157	94,157	17	1	0	0	
4115			VACATION & SICK - G&A	41,596		21	1	0	0	
4120	4475		EMPLOYEE BENEFITS	236,255	1,068,165	22	3	0	0	
4125			EMPLOYEE HEPETITIS VACCIN	0		22	3	0	0	
4130			EMPLOYEE SCHOLARSHIP WA	8,060	240,906	21	1	0	0	
4135			EMPLOYEE SCHOLARSHIP CC	6,169		23	3	0	0	
4220			DIRECTORS FEES	0	0	18	3	0	0	
4250	4255		OFFICE SUPPLIES	38,575	38,575	21	2	0	0	
4260			TELEPHONE	14,324	14,324	21	3	0	0	
4275			TRAINING & EMPLOYEE DEVL	195	195	23	3	16	0 **	
4280			GENERAL TRAVEL	3,576	4,756	24	3	16	0	
4281			MEAL EXPENSE FOR TRAVEL	0		24	3	19	0	
4285			EDUCATION & SEMINAR	1,180		24	3	19	-7,097 ***	
4290			HELP WANTED ADVERTISING	13,809	134,639	20	3	0	0	-77,409
4291			PROMOTIONAL ADVERTISING	9,658		20	3	25	-9,658	
4292			PUBLIC RELATIONS	6,645		20	3	25	-6,645	
4300			LICENSES & FEES	88,016		20	3	17	-498	
4310			DUES & SUBSCRIPTIONS	11,342		20	3	17	-6,408	
4320			CONTRIBUTIONS	10		27	3	20	-10	
4350			PROFESSIONAL FEES	26,874	545,367	19	3	22	-21,688	
4355			MEDICAL DIRECTOR	14,400	14,400	9	3	0	0	
4360			UTILIZATION REVIEW	0		10	3	0	0	
4361			OTHER PHYSICIAN FEES			39	3	0	0	
4362			MEDICAL RECORDS CONSULT	535		10	3	0	0	
4363			PHARMACIST FEES	9,149		10	3	0	0	
4364			SOC SERV/ACT CONSULT	1,955	1,955	12	3	0	0	
4370			TV RENTAL	25,094		35	3	5	0	
4380			INCOME TAXES		120,968	27	3	26	0	
4383			BACKGROUND CHECKS	5,169		20	3	26	0	
4400			PAYROLL TAXES	445,078		22	3	0	0	
4401			PAYROLL TAXES ADMINIST	0		22	3	0	0	
4410			GROUP INSURANCE	319,167		22	3	0	0	
4420			LIABILITY INSURANCE	82,563	82,563	26	3	0	0	
4425			INSURANCE-OWNERS			22	3	21	0	
4430			WORKMENS COMP INSURANC	53,436		22	3	0	0	
4450			CENTRAL OFFICE FEES	518,493		19	3	34	0 **	
4460			BAD DEBTS	120,083		27	3	24	-120,083	
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	59,060	84,154	35	3	16	0	
5110			MAINTENANCE SALARIES	99,776	109,075	6	1	0	0	
5120			MAINTENANCE SICK & VAC	9,299		6	1	0	0	
5130			ELECTRIC	61,866	121,886	5	3	0	0	
5131			NATURAL GAS	23,588		5	3	0	0	
5132			HEATING & DEISEL OIL			5	3	0	0	
5133			WATER & SEWER	36,432		5	3	0	0	
5134			TRASH COLLECTION	21,628	187,703	6	3	0	0	
5140			PROPERTY PLANT REPLACEM	15,401	73,123	6	2	0	0	
5160			GENERAL REPAIR & MAINT	57,722		6	2	0	0	
5165			MAINTENANCE CONTRACTS	166,075		6	3	0	0	
5210			DIETARY WAGES	514,622	537,466	1	1	0	0	
5220			DIETARY SICK & VAC	22,844		1	1	0	0	
5240			DIETARY CONSULTANT	7,920	7,920	2	3	13	0	
5248			FOOD PURCHASES	343,430	314,291	2	2	0	0	
5250			SUPPLIES-DISHWASHING	4,368	49,365	1	2	0	0	
5260			DIETARY REPLACEMENT	2,929		1	2	0	0	
5270			KITCHEN SUPPLIES-PAPER	42,068		1	2	0	0	
5295			MEAL CREDIT	-29,139		2	2	0	0	
5310			LAUNDRY WAGES	96,047	102,924	4	1	0	0	
5340			LAUNDRY SICK & VAC	6,877		4	1	0	0	
5370			LAUNDRY REPLACEMENT	19,840	26,429	4	2	0	0	
5380			LAUNDRY REIMBURSEMENT			4	3	0	0	
5390			LAUNDRY SUPPLIES	6,589		4	2	0	0	
5410			HOUSEKEEPING WAGES	249,791	264,143	3	1	0	0	
5440			HOUSEKEEPING SICK & VAC	14,352		3	1	0	0	
5480			HOUSEKEEPING SUPPLIES	46,884	46,923	3	2	0	0	
5490			HOUSEKEEPING SUPPLIES-PF	39		3	2	0	0	
6010			RN WAGES-MEDICARE		3,592,154	10	1	0	0	
6020			RN WAGES-NON MEDICARE	548,229		10	1	0	0	
6030			DON WAGES	56,544		10	1	0	0	
6035			ADON	109,112		10	1	0	0	
6040			RN SICK & VACATION	65,335		10	1	0	0	
6110			LPN WAGES-MEDICARE	985,142		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	64,030		10	1	0	0	
6210			AIDE WAGES-MEDICARE			10	1	0	0	
6220			AIDE WAGES-NON MEDICARE	1,629,054		10	1	0	0	
6230			WARD CLERKS			10	1	0	0	
6240			AIDE VACATION & SICK	81,922		10	1	0	0	
6245			CONTRACT NURSES-RN	375,546		10	3	0	0	
6246			CONTRACT NURSES-LPN	207,458		10	3	0	0	
6247			CONTRACT NURSES-AIDES	453,096		10	3	0	0	
6250			NURSE AIDE TRAINING WAGES	6,695	6,695	13	1	0	0	
6255			NURSE AID TRAINING EXP	5,538	5,538	13	2	0	0	
6260			NURSE AIDE TRAINING REIMB	0		0	0	0	0	
6270			REHAB WAGES	47,993		10	1	0	0	
6275			REHAB SICK & VAC	4,793		10	1	0	0	
6280			NURSING DEPT EDUCATION			23	3	0	0	
6290			NURSING SUPPLIES	21,232	265,735	10	2	0	0	
6295			NURSING SUPPLIES	242,982		10	2	0	0	
6390			REPLACEMENT-NURSING	1,521		10	2	0	0	
6490			NURSING OTHER	318	1,046,102	10	3	0	0	
7280			DRUG PURCHASES	260,948	261,528	39	2	0	0 ***	
7281			DRUG PURCHASES-OTHER	0		39	2			
7380			LABORATORY SERVICES	38,391	38,391	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	121,492	127,489	11	1	0	0	
7540			ACTIVITIES SICK & VAC	5,997		11	1	0	0	
7590			ACTIVITIES SUPPLIES	6,039	6,039	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	260,314	662,096	39	3	0	0 ***	
7660			PT SUPPLIES	580		39	2	0	0	
7710			SOCIAL SERVICE WAGES	119,021	127,860	12	1	0	0	
7720			SOCIAL SERVICE SICK & VAC	8,839		12	1	0	0	
7730			SOCIAL SERVICE EXPENSES	639	639	12	2	0	0	
7740			OT FEE	362,983		39	3	0	0 ***	
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0	
7770			SPEECH THERAPY FEE	38,799		39	3	0	0 ***	
7800			BEAUTICIAN WAGES		0	40	1	0	0	
7810			BEAUTICIAN SICK & VAC			40	1	0	0	
7820			BEAUTICIAN FEES	6,025	6,025	40	3	0	0	
7890			BEAUTY SHOP SUPPLIES	96	96	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	718,320	718,320	34	3	0	0	
8120			INTEREST EXPENSE	69,993	69,993	32	3	14	-810	
8130			DEPRECIATION	0	0	30	3	9	0	
8150			LOAN FEE AMORTIZATION	0		32	3	0	0	
9510			INTEREST INCOME	-810		32	0	10	0	
9520			MISC NON-OPERATING INCOM	0		0	0	0	0	
9700			INCOME TAXES	875		0	0	0	-875	
				11,498,254	11,739,970					
					241,716					
GRAND TOTALS				1,008,317					-173,772	
				(NET INCOME)						
				0						

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 162

BALANCE SHEET TOTAL 0

1,009	1,009	CASH	400
1,100	1,100	ACCTS RE	272,022
1,101	1,101	ALLOW. F	(219,995)
1,110	1,110	ACCTS RECEIV-M/C	
1,125	1,125	ACCTS RECEIV-IPA	
1,132	1,132	US HHS S	(137,896)
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	5,727
1,300	1,300	DIETARY I	18,784
1,310	1,310	SUPPLIES INVENTORY	
1,320	1,320	LINEN INVENTORY	
1,409	1,409	LAND	0
1,450	1,450	FURNITUF	0
1,460			0
1,475	1,475	BUILDINGS	0
1,490	1,490	ACCUM DI	0
1,530	1,530	RESIDENT	32,830
1,550	1,550	LOAN FEE	0
1,551	1,551	LOAN FEES ADDED	
1,850	1,850	INTERCO	(1,172,723)
2,010	2,010	ACCOUNT	0
2,100	2,095	BONUSES PAYABLE	
2,100	2,100	ACCRUED	(202,987)
2,100	2,100	PR CLEARING-BENEFITS	
2,100	2,100	PR CLEARING-LABOR	
2,110	2,110	ACCRUED	(208,833)
2,120	2,120	U.C. TAXE	0
2,125	2,125	FICA TAXE	(3,171)
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 PAYME	(19,624)
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	(32,830)
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	659,979
		net income	1,008,317
		balance	0

3,007	3,007	PATIENT D	16,144
3,007	3,007	PATIENT D	22,013
3,007	3,007	PATIENT D	2,078
3,007			0
3,007			
3,007			
3,007			
3,010	3,010	BASIC CH	(9,713,599)
3,020	3,020	BASIC CH	0
3,030	3,030	BASIC CH	0
3,040		ASSESSM	240,906
3,050			0
3,060			0
3,061			0
3,080	3,080	NURSING	(1,372)
3,081	3,081	NURSING	0
3,082	3,082	NURSING	0
3,083	3,083	NURSING	0
3,100	3,100	DRUGS-M	(365,236)
3,101			0
3,110	3,110	PHYSICAL	(1,703,020)
3,111			0
3,112	3,112	PHYSICAL	0
3,113	3,113	PHYSICAL	0
3,140	3,140	LABORATORY INCOME	
3,150			0
3,151			
3,152	3,152	ST/OT TH	0
3,153	3,153	ST/OT TH	0
3,160	3,185	REHAB/ISOLATION/OTHER CHG	
3,410	3,410	IPA/OTHE	0
3,411	3,411	MEDICAR	0
3,420	3,420	MEDICAR	1,718,681
3,452	3,452	HHS STIM	(694,570)
3,520	3,520	RENT INC	0
3,530	3,530	BEAUTY S	(7,096)
3,560			0
3,570	3,570	VENDING	0
3,590	3,590	EQUIPME	(124)
3,595	3,595	RESIDENT	0
3,600	3,600	MISC INC	704
4,110	4,110	G&A WAG	477,302
4,111	4,111	ADMINIST	94,157
4,115	4,115	G&A PTO	41,596
4,120	4,120	EMPLOYE	235,595
4,121			0
4,130	4,130	EMPLOYE	8,060
4,135	4,135	EMPLOYE	6,169
4,250	4,250	OFFICE S	15,488
4,255	4,255	POSTAGE	7,096
4,260	4,260	TELEPHO	14,324
4,275	4,275	TRAINING	195
4,276			0
4,280	4,280	GENERAL	3,576
4,281	4,281	MEAL EXP	0
4,285	4,285	EDUCATIO	1,180
4,289	4,289	MEETINGS	0
4,290	4,290	HELP WA	13,809
4,291	4,291	PROMOTI	9,658
4,292	4,292	PUBLIC R	6,645
4,300	4,300	LICENSE &	88,016
4,310	4,310	DUES & S	11,342
4,320	4,320	CONTRIB	10
4,350	4,350	PROFESS	26,874
4,355	4,355	MEDICAL	14,400
4,362			535
4,363			9,149
4,364	4,364	SOCIAL S	1,955
4,370	4,370	TV RENTA	25,094
4,383	4,383	BACKGRO	5,169
4,390	4,390	OTHER TA	875
4,400	4,400	PAYROLL	445,078
4,401	4,401	PAYROLL	0
4,410	4,410	GROUP IN	319,167
4,420	4,420	LIABILITY	82,563
4,430	4,430	WORKMA	48,706
4,435	4,435	W/C-FIRS	0
4,436	4,436	DRUG TES	4,730
4,450	4,450	MANAGEM	518,493
4,460	4,460	BAD DEBT	120,083
4,461	4,461	BAD DEBT	34,789
4,470	4,470	LOST ITEM	0
4,475	4,475	UNIFORM	660
4,486	4,486	SERVICE	107,969
4,490	4,490	MISC EXP	3,822
4,496	4,496	MISC. M.I.S	15,991
4,510	4,510	REAL EST	0
4,600	4,600	LEASED E	59,060
5,110	5,110	MAINTENA	99,776
5,120	5,120	MAINTENA	9,299
5,130	5,130	ELECTRIC	61,866
5,131	5,131	NATURAL	23,588
5,133	5,133	WATER &	36,432
5,134	5,134	TRASH CO	21,628
5,140	5,140	PROP/PLA	15,401
5,160	5,160	GENERAL	57,722
5,165	5,165	MAINTENA	58,106
5,210	5,210	DIETARY	514,622
5,220	5,220	DIETARY	22,844
5,248	5,248	FOOD PU	339,608
5,250	5,250	SUPPLIES	4,368
5,260	5,260	REPLACE	2,929
5,270	5,270	KITCHEN	42,068
5,295	5,295	MEAL INC	(29,139)
5,310	5,310	LAUNDRY	96,047
5,340	5,340	LAUNDRY	6,877
5,370	5,370	REPLACE	19,840
5,230	5,230	DIETARY	7,920
5,390	5,390	LAUNDRY	6,589
5,410	5,410	HOUSEKE	249,791
5,440	5,440	HOUSEKE	14,352
5,480	5,480	SUPPLIES	46,884
5,490	5,490	SUPPLIES	39
6,020	6,020	RN WAGE	548,229
6,030	6,030	DON WAG	56,544
6,035	6,035	ADON WA	109,112
6,040	6,040	RN PTO &	65,335
6,120	6,120	LPN WAG	985,142
6,140	6,140	LPN PTO	64,030
6,220	6,220	AIDES WA	1,629,054
6,240	6,240	AIDES PT	81,922
6,245		RN CONT	375,546
6,246		LPN CONT	207,458
6,247		AIDES CO	453,096
6,250			6,695
6,255			5,538
6,260			0
6,270	6,270	REHAB W	47,993
6,275	6,275	REHAB PT	4,793
6,290	6,290	NURSING	21,232
6,295	6,295	NURSING	242,982
6,390	6,390	REPLACE	1,521
6,490	6,490	OTHER	318
7,280	7,280	DRUG PU	260,948
7,281	7,281	DRUG PU	0
7,380	7,380	LABORAT	16,006
7,391	7,390	X-RAY SE	22,420
7,393			(35)
7,510	7,510	ACTIVITIE	121,492
7,540	7,540	ACTIVITIE	5,997
7,590	7,590	ACTIVITIE	6,039
7,620	7,620	PHYSICAL	260,314
7,660	7,660	P.T. SUPP	580
7,710	7,710	SOCIAL S	119,021
7,720	7,720	SOCIAL S	8,839
7,730	7,730	SOCIAL S	0
7,740	7,740	OCCUPAT	362,983
7,750			639
7,770	7,770	SPEECH T	38,799
7,820	7,820	BEAUTICI	6,025
7,890			96
7,960			0
8,120	8,120	INTEREST	1,488
8,125			68,505
8,130	8,130	DEPRECI	0
8,150			0
9,510	9,510	INTEREST	(810)
9,520	9,520	MISC NON	0
9,530	4,220		0
	8,100		718,320
	9,702		0
	5,230		0
			1,008,317

Expenses Fixed Assets
0

Heritage Manor - Normal
IDPH ID# 48157
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	$	260,948
Purchased Hospital Services		12,004
Purchased Laboratory Services		16,006
Purchased Radiology Services		10,381
Amount Reclassified to Line 39	$	299,339

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

Line Item		
Provider Participation Fee - $1.50	$	(77,409)
Provider Assesment Fee - $6.07		(240,906)
	$	(318,315)
Provider Participation Fee	$	318,315

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

Line Item		
Pharmacy Consulting Fees	$	9,149