

		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>0048884</u></p> <p><b>Facility Name:</b> <u>Heritage Health Pana</u></p> <p><b>Address:</b> <u>1000 E Sixth St Road</u> <u>Pana</u> <u>62557</u>                                        Number                                City                                Zip Code</p> <p><b>County:</b> <u>Christian</u></p> <p><b>Telephone Number:</b> <u>( 217 ) 324-2153</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: 15%; padding: 5px;"><b>Officer or Administrator of Provider</b></td> <td style="padding: 5px;">           (Signed) _____            (Type or Print Name) <u>David M Underwood</u>            (Title) <u>EVP &amp; CFO</u> </td> </tr> <tr> <td style="padding: 5px;"><b>Paid Preparer</b></td> <td style="padding: 5px;">           (Signed) _____            (Print Name and Title) _____            (Firm Name &amp; Address) _____            (Telephone) <u>( )</u> Fax # ( )         </td> </tr> </table> <p align="right"><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b>      <b>Phone # (217) 782-1630</b></p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) <u>David M Underwood</u> (Title) <u>EVP &amp; CFO</u>	<b>Paid Preparer</b>	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> 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 _____						
<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) <u>David M Underwood</u> (Title) <u>EVP &amp; CFO</u>							
<b>Paid Preparer</b>	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # ( )							

Facility Name & ID Number Heritage Health Pana

# 0048884 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	128	Skilled (SNF)	128	46,848	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	128	TOTALS	128	46,848	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	18,881	7,176	5,622	31,679	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,881	7,176	5,622	31,679	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 67.62%

**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 128 and days of care provided 5,622

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 Pana # 0048884 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	297,341	32,824	7,338	337,503		337,503	6,245	343,748		1
2	Food Purchase		299,962		299,962		299,962	(22)	299,940		2
3	Housekeeping	133,172	35,166		168,338		168,338	8,326	176,664		3
4	Laundry	72,262	28,346		100,608		100,608	595	101,203		4
5	Heat and Other Utilities			156,095	156,095		156,095	1,982	158,077		5
6	Maintenance	81,590	79,066	102,986	263,642		263,642	24,298	287,940		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	584,365	475,364	266,419	1,326,148		1,326,148	41,424	1,367,572		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			15,750	15,750		15,750		15,750		9
10	Nursing and Medical Records	2,524,393	186,633	416,204	3,127,230	(7,602)	3,119,628	8,268	3,127,896		10
10a	Therapy		239,383	47,371	286,754	(278,362)	8,392		8,392		10a
11	Activities	76,707	1,251		77,958		77,958	7	77,965		11
12	Social Services	57,291		3,148	60,439		60,439	179	60,618		12
13	CNA Training	9,382	4,657		14,039		14,039		14,039		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,667,773	431,924	482,473	3,582,170	(285,964)	3,296,206	8,454	3,304,660		16
	<b>C. General Administration</b>										
17	Administrative	85,028			85,028		85,028		85,028		17
18	Directors Fees										18
19	Professional Services			469,706	469,706		469,706	(442,747)	26,959		19
20	Dues, Fees, Subscriptions & Promotions			288,821	288,821	(244,930)	43,891	(29,632)	14,259		20
21	Clerical & General Office Expenses	341,773	31,836	11,342	384,951		384,951	532,816	917,767		21
22	Employee Benefits & Payroll Taxes			696,962	696,962		696,962	53,657	750,619		22
23	Inservice Training & Education			392	392		392	1,615	2,007		23
24	Travel and Seminar			2,962	2,962		2,962	2,037	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			73,227	73,227		73,227	88,889	162,116		26
27	Other (specify):* <b>Lost resident items</b>			93,390	93,390		93,390	(93,407)	(17)		27
28	<b>TOTAL General Administration</b>	426,801	31,836	1,636,802	2,095,439	(244,930)	1,850,509	113,228	1,963,737		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,678,939	939,124	2,385,694	7,003,757	(530,894)	6,472,863	163,106	6,635,969		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 Pana

#0048884

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							295,234	295,234			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			62,201	62,201		62,201	190,303	252,504			32
33	Real Estate Taxes							75,482	75,482			33
34	Rent-Facility & Grounds			661,380	661,380		661,380	(652,133)	9,247			34
35	Rent-Equipment & Vehicles			64,363	64,363		64,363	16,371	80,734			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			787,944	787,944		787,944	(74,743)	713,201			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,295,725	1,295,725	285,964	1,581,689	271,548	1,853,237			39
40	Barber and Beauty Shops	8,211	186		8,397		8,397		8,397			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					244,930	244,930		244,930			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>	8,211	186	1,295,725	1,304,122	530,894	1,835,016	271,548	2,106,564			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,687,150	939,310	4,469,363	9,095,823		9,095,823	359,911	9,455,734			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	(4,857)			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	(6,397)			17
18	Fines and Penalties				18
19	Entertainment	(4,626)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,586)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(93,407)			24
25	Fund Raising, Advertising and Promotional	(24,464)			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>	\$ (138,337)		\$	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)	498,248		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 498,248		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 359,911		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 Pana

ID# 0048884

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		(4,586)	19	11
12		(4,857)	32	12
13		(93,407)	27	13
14		(24,464)	20	14
15		(6,397)	20	15
16		0	27	16
17		(4,626)	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>	(138,337)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Pana# 0048884

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	6,245	0	0	0	0	0	0	0	0	6,245	1
2	Food Purchase	0	0	(22)	0	0	0	0	0	0	0	0	(22)	2
3	Housekeeping	0	0	8,326	0	0	0	0	0	0	0	0	8,326	3
4	Laundry	0	0	595	0	0	0	0	0	0	0	0	595	4
5	Heat and Other Utilities	0	0	1,982	0	0	0	0	0	0	0	0	1,982	5
6	Maintenance	0	0	24,298	0	0	0	0	0	0	0	0	24,298	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	41,424	0	0	0	0	0	0	0	0	41,424	8
	<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	(24,072)	32,340	0	0	0	0	0	0	0	0	8,268	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	179	0	0	0	0	0	0	0	0	179	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>	0	(24,072)	32,526	0	0	0	0	0	0	0	0	8,454	16
	<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	(4,586)	(459,359)	21,198	0	0	0	0	0	0	0	0	(442,747)	19
20	Fees, Subscriptions & Promotions	(30,861)	0	1,229	0	0	0	0	0	0	0	0	(29,632)	20
21	Clerical & General Office Expenses	0	0	532,816	0	0	0	0	0	0	0	0	532,816	21
22	Employee Benefits & Payroll Taxes	0	0	53,657	0	0	0	0	0	0	0	0	53,657	22
23	Inservice Training & Education	0	(72)	1,687	0	0	0	0	0	0	0	0	1,615	23
24	Travel and Seminar	(4,626)	0	6,663	0	0	0	0	0	0	0	0	2,037	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	88,889	0	0	0	0	0	0	0	0	88,889	26
27	Other (specify):*	(93,407)	0	0	0	0	0	0	0	0	0	0	(93,407)	27
28	<b>TOTAL General Administration</b>	(133,480)	(459,431)	706,139	0	0	0	0	0	0	0	0	113,228	28
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	(133,480)	(483,503)	780,089	0	0	0	0	0	0	0	0	163,106	29

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Pana# 0048884

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 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)	
	<b>D. Ownership</b>													
30	Depreciation	0	265,199	0	30,035	0	0	0	0	0	0	0	295,234	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,857)	191,789	0	3,371	0	0	0	0	0	0	0	190,303	32
33	Real Estate Taxes	0	75,482	0	0	0	0	0	0	0	0	0	75,482	33
34	Rent-Facility & Grounds	0	(661,380)	0	9,247	0	0	0	0	0	0	0	(652,133)	34
35	Rent-Equipment & Vehicles	0	0	0	16,371	0	0	0	0	0	0	0	16,371	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(4,857)</b>	<b>(128,910)</b>	<b>0</b>	<b>59,024</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(74,743)</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	271,307	0	241	0	0	0	0	0	0	0	271,548	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>271,307</b>	<b>0</b>	<b>241</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>271,548</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(138,337)</b>	<b>(341,106)</b>	<b>780,089</b>	<b>59,265</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>359,911</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
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.**  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		\$ (24,072)	\$ (24,072)	1
2	V	23 Adjustment for Related Organization		GreenTree Pharmacy		(72)	(72)	2
3	V	39 Adjustment for Related Organization		GreenTree Pharmacy		271,307	271,307	3
4	V	19 Adjustment for Related Organization	459,359	Heritage Operations Group, LLC			(459,359)	4
5	V							5
6	V	34 Adjustment for Related Organization	661,380	Heritage Manor Real Estate, LLC			(661,380)	6
7	V	33 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		75,482	75,482	7
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		180,902	180,902	8
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		265,199	265,199	9
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		10,887	10,887	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,120,739			\$ 779,633	\$ * (341,106)	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		\$ 6,245	\$ 6,245
16	V	2 Food Purchase		Heritage Operations Group		(22)	(22)
17	V	3 Housekeeping		Heritage Operations Group		8,326	8,326
18	V	4 Laundry		Heritage Operations Group		595	595
19	V	5 Heat & Other Utilities		Heritage Operations Group		1,982	1,982
20	V	6 Maintenance		Heritage Operations Group		24,298	24,298
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		32,340	32,340
24	V	11 Activities		Heritage Operations Group		7	7
25	V	12 Social Service		Heritage Operations Group		179	179
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		21,198	21,198
32	V	20 Fees, Subscription, Promotions		Heritage Operations Group		1,229	1,229
33	V	21 Clerical & General Office Expenses		Heritage Operations Group		532,816	532,816
34	V	22 Employee Benefits & Payroll Taxes		Heritage Operations Group		53,657	53,657
35	V	23 Inservice Training & Education		Heritage Operations Group		1,687	1,687
36	V	24 Travel and Seminar		Heritage Operations Group		6,663	6,663
37	V	25 Other Admin. Staff Transportation		Heritage Operations Group		0	
38	V	26 Insurance-Prop.Liab.Malpract		Heritage Operations Group		88,889	88,889
39	Total		\$			\$ 780,089	\$ * 780,089

\* 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		30,035	30,035	16	
17	V	31		Heritage Operations Group		0		17	
18	V	32		Heritage Operations Group		3,371	3,371	18	
19	V	33		Heritage Operations Group		0		19	
20	V	34		Heritage Operations Group		9,247	9,247	20	
21	V	35		Heritage Operations Group		16,371	16,371	21	
22	V	36		Heritage Operations Group		0		22	
23	V	38		Heritage Operations Group		0		23	
24	V	39		Heritage Operations Group		241	241	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		\$			\$ 59,265	\$ *	59,265	39

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

Facility Name & ID Number Heritage Health Pana # 0048884 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	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 Pana

# 0048884

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	128	\$ 6,245	1
2	2	Food Purchase	Beds	2,493	25	(423)	0	128	(22)	2
3	3	Housekeeping	Beds	2,493	25	162,156	0	128	8,326	3
4	4	Laundry	Beds	2,493	25	11,591	0	128	595	4
5	5	Heat & Other Utilities	Beds	2,493	25	38,605	0	128	1,982	5
6	6	Maintenance	Beds	2,493	25	473,233	88,567	128	24,298	6
7	7	Other	Beds	2,493	25	0	0	128	0	7
8	9	Medical Director	Beds	2,493	25	0	0	128	0	8
9	10	Nursing & Medical Records	Beds	2,493	25	629,872	35,401	128	32,340	9
10	11	Activities	Beds	2,493	25	129	0	128	7	10
11	12	Social Service	Beds	2,493	25	3,478	3,478	128	179	11
12	13	Nurse Aide Training	Beds	2,493	25	0	0	128	0	12
13	14	Program Transportation	Beds	2,493	25	0	0	128	0	13
14	15	Other	Beds	2,493	25	0	0	128	0	14
15	17	Administrative	Beds	2,493	25	0	0	128	0	15
16	18	Directors Fees	Beds	2,493	25	0	0	128	0	16
17	19	Professional Services	Beds	2,493	25	412,869	0	128	21,198	17
18	20	Fees, Subscription, Promotions	Beds	2,493	25	23,945	0	128	1,229	18
19	21	Clerical & General Office Expense	Beds	2,493	25	10,377,428	9,978,005	128	532,816	19
20	22	Employee Benefits & Payroll Tax	Beds	2,493	25	1,045,059	0	128	53,657	20
21	23	Inservice Training & Education	Beds	2,493	25	32,865	0	128	1,687	21
22	24	Travel and Seminar	Beds	2,493	25	129,776	0	128	6,663	22
23	25	Other Admin. Staff Transportatio	Beds	2,493	25	0	0	128	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,493	25	1,731,253	0	128	88,889	24
25	TOTALS					\$ 15,193,470	\$ 10,226,789		\$ 780,089	25

Facility Name & ID Number Heritage Health Pana

# 0048884

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	\$	\$	128	\$	1
2	30	Depreciation	Beds	2,493	25	584,981	128	30,035		2
3	31	Amortization of Pre-Op & Org	Beds	2,493	25		128			3
4	32	Interest	Beds	2,493	25	65,658	128	3,371		4
5	33	Real Estate Taxes	Beds	2,493	25		128			5
6	34	Rent-Facility & Grounds	Beds	2,493	25	180,106	128	9,247		6
7	35	Rent-Equipment & Vehicles	Beds	2,493	25	318,843	128	16,371		7
8	36	Other	Beds	2,493	25		128			8
9	38	Medically Nec Transportation	Beds	2,493	25		128			9
10	39	Ancillary Service Centers	Beds	2,493	25	4,685	128	241		10
11	40	Barber and Beauty Shops	Beds	2,493	25		128			11
12	41	Coffee and Gift Shops	Beds	2,493	25		128			12
13	42	Other	Beds	2,493	25		128			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	\$	\$ 59,265		25

Facility Name & ID Number

Heritage Health Pana

# 0048884

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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Busey Bank		xx	Mortgage			\$	\$		\$ 180,902	1									
2	Busey Bank		xx	Loan Fee Amortization						10,887	2									
3											3									
4											4									
5											5									
<b>Working Capital</b>																				
6	Busey Bank		xx	Working Capital						62,201	6									
7											7									
8											8									
9	<b>TOTAL Facility Related</b>						\$	\$		\$ 253,990	9									
<b>B. Non-Facility Related*</b>																				
10	Interest Income									(4,857)	10									
11											11									
12	Allocated Corporate									3,371	12									
13											13									
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$ (1,486)	14									
15	<b>TOTALS (line 9+line14)</b>						\$	\$		\$ 252,504	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.)

**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>75,482</b> 2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>75,482</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>75,482</b> 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	<b>73,303</b>	8
	2016	<b>73,397</b>	9
	2017	<b>74,208</b>	10
	2018	<b>73,741</b>	11
	2019	<b>75,482</b>	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.**





Facility Name & ID Number Heritage Health Pana

# 0048884 Report Period Beginning:

1/1/2020 Ending:

12/31/2020

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 38,600 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

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

If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			Mar-96	\$ 51,055	1
2					2
3	TOTALS			\$ 51,055	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	128			\$ 3,943,054	\$		\$	\$	4
5									5
6									6
7									7
8									8
<b>Improvement Type**</b>									
9	1996 Improvements		1996	7,891					9
10	1997 Improvements		1997	1,113					10
11	1998 Improvements		1998	27,979					11
12	1999 Improvements		1999	113,936					12
13	2000 Improvements		2000	2,885					13
14	2001 Improvements		2001	2,826					14
15	2002 Improvements		2002	5,414					15
16	2003 Improvements		2003	11,949					16
17	2004 Improvements		2004	40,924					17
18	2005 Improvements		2005	27,755					18
19	2006 Improvements		2006	78,460					19
20	2007 Improvements		2007	95,951					20
21	2008 Improvements		2008	76,846					21
22	2009 Improvements		2009	1,069,078					22
23	2010 Improvements		2010	243,075					23
24	2011 Improvements		2011	38,553					24
25	2012 Improvements		2012	181,661					25
26	2013 Improvements		2013	56,859					26
27	2014 Improvements		2014	227,709					27
28									28
29									29
30									30
31									31
32									32
33									33
34	C/O Allocation				30,035		30,035		34
35	Book Depreciation				247,758		247,758		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

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		\$	\$		\$	\$	\$	37
38	2015	7,215						38
39	2015	2,813						39
40	2015	14,500						40
41	2015	4,636						41
42								42
43	2016							43
44								44
45	2017	2,759						45
46								46
47	2018	10,799						47
48	2018	9,965						48
49	2018	2,779						49
50								50
51	2019	18,495						51
52								52
53	2020	2,541						53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70		\$ 6,330,420	\$ 277,793		\$ 277,793	\$	\$	70

\*\*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	\$ 1,103,663	\$ 17,441	\$ 17,441	\$		\$	71
72	Current Year Purchases	24,708						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,128,371	\$ 17,441	\$ 17,441	\$		\$	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)	\$ 7,509,846	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 295,234	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 295,234	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 Pana

# 0048884

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: \$ 64,363 Description: Mattresses, televisions, CPM's 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	<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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		4,657		4,657
3	Classroom Wages (a)				
4	Clinical Wages (b)		9,382		9,382
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 14,039	\$	\$ 14,039
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$	14,039		

**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	\$		\$ 586,855	\$		\$ 586,855	1
2	Licensed Speech and Language Development Therapist		hrs			125,739			125,739	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			583,131	790		583,921	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				238,593		238,593	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					47,371			47,371	13
14	TOTAL			\$		\$ 1,343,096	\$ 239,383		\$ 1,582,479	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.



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	\$ 1,288	\$	1
2	Cash-Patient Deposits	41,761		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	868,370		3
4	Supply Inventory (priced at <u>FIFO</u> )	10,255		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,311		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	205,581		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,128,566	\$	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>	\$ 1,128,566	\$	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	41,761		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	365,503		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,821		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>	14,695		36
37	<u>Deferred Stimulus</u>	73,995		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 508,775	\$	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>	\$ 508,775	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 619,791	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,128,566	\$	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>255,520</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>255,520</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	\$ <b>364,271</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>364,271</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>619,791</b>	<b>24</b> *

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

**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	\$ 7,810,688	1
2	Discounts and Allowances for all Levels	(3,332,730)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,477,958	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,675,178	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 3,675,178	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants	821,082	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,572	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	452,812	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	23,635	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,302,101	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	4,857	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 4,857	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>	\$ 9,460,094	30

2			
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,326,148	31
32	Health Care	3,582,170	32
33	General Administration	2,095,439	33
<b>B. Capital Expense</b>			
34	Ownership	787,944	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,304,122	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>	\$ 9,095,823	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	364,271	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 364,271	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 Pana

# 0048884

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	1,856	1,933	\$ 72,337	\$ 37.42	1
2	Assistant Director of Nursing	1,738	1,811	52,628	29.06	2
3	Registered Nurses	7,747	8,070	285,194	35.34	3
4	Licensed Practical Nurses	24,199	25,208	658,862	26.14	4
5	CNAs & Orderlies	77,820	81,062	1,337,406	16.50	5
6	CNA Trainees	914	952	9,382	9.86	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,763	4,961	117,966	23.78	8
9	Activity Director					9
10	Activity Assistants	5,385	5,610	76,707	13.67	10
11	Social Service Workers	3,501	3,647	57,291	15.71	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,734	25,765	297,341	11.54	15
16	Dishwashers					16
17	Maintenance Workers	4,955	5,162	81,590	15.81	17
18	Housekeepers	11,029	11,488	133,172	11.59	18
19	Laundry	5,912	6,158	72,262	11.73	19
20	Administrator	2,003	2,087	85,028	40.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,602	14,168	341,773	24.12	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) <u>Beauticians</u>	647	674	8,211	12.18	33
34	TOTAL (lines 1 - 33)	190,805	198,756	\$ 3,687,150 *	\$ 18.55	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	\$ 7,338	L1 C3	35
36	Medical Director	15,750	L9 C3	36
37	Medical Records Consultant	13,937	L10 C3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	7,602	L10A C3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	3,148	L12 C3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 47,775		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 53,809	L10 C3	50
51	Licensed Practical Nurses	43,848	L10 C3	51
52	Certified Nurse Assistants/Aides	296,489	L10 C3	52
53	TOTAL (lines 50 - 52)	\$ 394,146		53

Facility Name & ID Number **Heritage Health Pana**

# **0048884**

Report Period Beginning: **1/1/2020**

Ending: **12/31/2020**

**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	
<b>Carl Portz</b>	<b>Administrator</b>		\$ <b>85,028</b>	<b>Workers' Compensation Insurance</b>	\$ <b>37,888</b>	<b>IDPH License Fee</b>	\$	
				<b>Unemployment Compensation Insurance</b>	<b>14,143</b>	<b>Advertising: Employee Recruitment</b>	<b>5,158</b>	
				<b>FICA Taxes</b>	<b>282,067</b>	<b>Health Care Worker Background Check</b>		
				<b>Employee Health Insurance</b>	<b>127,953</b>	(Indicate # of checks performed _____)	<b>2,252</b>	
				<b>Employee Meals</b>		<b>Patient Background Checks</b>		
				<b>Illinois Municipal Retirement Fund (IMRF)*</b>				
						<b>PR</b>	<b>6,989</b>	
				<b>Other Benefits</b>	<b>234,911</b>	<b>Dues &amp; Subscriptions</b>	<b>9,757</b>	
				<b>Central Office Allocation</b>	<b>53,657</b>	<b>License &amp; Fees</b>	<b>2,260</b>	
						<b>Central Office Allocation</b>	<b>1,229</b>	
						<b>Less: Public Relations Expense</b>	<b>(6,989)</b>	
						<b>Non-allowable advertising</b>	<b>(6,397)</b>	
						<b>Yellow page advertising</b>	( )	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			\$ <b>85,028</b>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>	\$ <b>750,619</b>	<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>	\$ <b>14,259</b>	
<b>(List each licensed administrator separately.)</b>								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	<b>Out-of-State Travel</b>	\$
							<b>In-State Travel</b>	
								<b>2,601</b>
								<b>22</b>
							<b>Seminar Expense</b>	<b>339</b>
								<b>2,037</b>
							<b>Entertainment Expense</b>	( )
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			\$	<b>TOTAL</b>		\$	<b>TOTAL (agree to Sch. V, line 24, col. 8)</b>	\$ <b>4,999</b>
<b>(Attach a copy of any management service agreement)</b>								
C. Professional Services								
Vendor/Payee	Type		Amount					
<b>Heritage Operations Group</b>	<b>Management</b>		\$ <b>465,120</b>					
<b>Legal adj to Zero</b>			<b>4,586</b>					
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			\$ <b>469,706</b>					
<b>(For legal fee disclosure, see page 39 of instructions)</b>								

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name &amp; ID Number Heritage Health Pana

# 0048884

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 - \$8,960
- (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. \$ 244,930  
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. \$ 748
- (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 - Pana  
IDPH ID# 48884  
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	\$	238,593
Purchased Hospital Services		6,358
Purchased Laboratory Services		33,216
Purchased Radiology Services		7,797
Amount Reclassified to Line 39	\$	<u>285,964</u>

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

<u>Line Item</u>		
Provider Participation Fee - \$1.50	\$	(70,272)
Provider Assesment Fee - \$6.07		(174,658)
	\$	<u>(244,930)</u>
Provider Participation Fee	\$	<u>244,930</u>

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

<u>Line Item</u>		
Pharmacy Consulting Fees	\$	<u>7,602</u>