		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: 0048090

Facility Name: Heritage Health Peru

Address: 1301 21st Street (Number) | Peru (City) | 61354 (Zip Code)

County: LaSalle

Telephone Number: (815) 223-4901 Fax # ( )

HFS ID Number:

Date of Initial License for Current Owners: July 2006

Type of Ownership:

- [ ] VOLUNTARY,NON-PROFIT
  - [ ] Charitable Corp.
  - [ ] Trust
- IRS Exemption Code ______
- [xx] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [xx] Limited Liability Co.
  - [ ] Trust
  - [ ] Other ______
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] 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 Peru # 0048090 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	127	Skilled (SNF)	127	46,482	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	127	TOTALS	127	46,482	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	20,019	5,664	4,301	29,984	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,019	5,664	4,301	29,984	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.51%

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 127 and days of care provided 4,301

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 Peru # 0048090 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	271,797	22,859	8,169	302,825		302,825	6,196	309,021			1
2	Food Purchase		272,396		272,396		272,396	(22)	272,374			2
3	Housekeeping	123,558	57,526		181,084		181,084	8,261	189,345			3
4	Laundry	40,481	9,485		49,966		49,966	590	50,556			4
5	Heat and Other Utilities			119,299	119,299		119,299	1,967	121,266			5
6	Maintenance	150,069	109,668	136,393	396,130		396,130	24,108	420,238			6
7	Other (specify):*											7
8	**TOTAL General Services**	585,905	471,934	263,861	1,321,700		1,321,700	41,100	1,362,800			8
	B. Health Care and Programs											
9	Medical Director			28,421	28,421		28,421		28,421			9
10	Nursing and Medical Records	3,061,357	232,360	14,368	3,308,085	(7,231)	3,300,854	6,384	3,307,238			10
10a	Therapy		287,587	136,511	424,098	(416,867)	7,231		7,231			10a
11	Activities	160,216	1,269		161,485		161,485	7	161,492			11
12	Social Services	70,604		1,845	72,449		72,449	177	72,626			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,292,177	521,216	181,145	3,994,538	(424,098)	3,570,440	6,568	3,577,008			16
	C. General Administration											
17	Administrative	101,194			101,194		101,194		101,194			17
18	Directors Fees											18
19	Professional Services			443,089	443,089		443,089	(417,245)	25,844			19
20	Dues, Fees, Subscriptions & Promotions			272,150	272,150	(231,847)	40,303	(27,682)	12,621			20
21	Clerical & General Office Expenses	327,268	30,981	8,718	366,967		366,967	528,654	895,621			21
22	Employee Benefits & Payroll Taxes			672,551	672,551		672,551	53,238	725,789			22
23	Inservice Training & Education			162	162		162	1,602	1,764			23
24	Travel and Seminar			5,075	5,075		5,075	(76)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			68,962	68,962		68,962	88,195	157,157			26
27	Other (specify):* Lost resident items			(11,129)	(11,129)		(11,129)	11,290	161			27
28	**TOTAL General Administration**	428,462	30,981	1,459,578	1,919,021	(231,847)	1,687,174	237,976	1,925,150			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,306,544	1,024,131	1,904,584	7,235,259	(655,945)	6,579,314	285,644	6,864,958			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							278,574	278,574			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			63,680	63,680		63,680	111,966	175,646			32
33	Real Estate Taxes							54,666	54,666			33
34	Rent-Facility & Grounds			568,451	568,451		568,451	(555,845)	12,606			34
35	Rent-Equipment & Vehicles			38,215	38,215		38,215	16,243	54,458			35
36	Other (specify):*											36
37	**TOTAL Ownership**			670,346	670,346		670,346	(94,396)	575,950			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			970,790	970,790	424,098	1,394,888	213,442	1,608,330			39
40	Barber and Beauty Shops			1,873	1,873		1,873		1,873			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					231,847	231,847		231,847			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			972,663	972,663	655,945	1,628,608	213,442	1,842,050			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,306,544	1,024,131	3,547,593	8,878,268		8,878,268	404,690	9,282,958			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 Peru # 0048090 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	(4,762)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(6,162)			17
18	Fines and Penalties	(1,100)			18
19	Entertainment	(6,687)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(12,880)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	12,390			24
25	Fund Raising, Advertising and Promotional	(22,740)			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)**	$ (41,941)		$	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)	446,631		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 446,631		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 404,690		37

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

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

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

STATE OF ILLINOIS

Heritage Health Peru

ID# 0048090

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		(12,880)	19	11
12		(4,762)	32	12
13		12,390	27	13
14		(22,740)	20	14
15		(6,162)	20	15
16		(1,100)	27	16
17		(6,687)	24	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(41,941)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Peru # 0048090 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	6,196	0	0	0	0	0	0	0	0	6,196	1
2	Food Purchase	0	0	(22)	0	0	0	0	0	0	0	0	(22)	2
3	Housekeeping	0	0	8,261	0	0	0	0	0	0	0	0	8,261	3
4	Laundry	0	0	590	0	0	0	0	0	0	0	0	590	4
5	Heat and Other Utilities	0	0	1,967	0	0	0	0	0	0	0	0	1,967	5
6	Maintenance	0	0	24,108	0	0	0	0	0	0	0	0	24,108	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	41,100	0	0	0	0	0	0	0	0	41,100	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	(25,703)	32,087	0	0	0	0	0	0	0	0	6,384	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	177	0	0	0	0	0	0	0	0	177	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	(25,703)	32,271	0	0	0	0	0	0	0	0	6,568	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	(12,880)	(425,398)	21,033	0	0	0	0	0	0	0	0	(417,245)	19
20	Fees, Subscriptions & Promotions	(28,902)	0	1,220	0	0	0	0	0	0	0	0	(27,682)	20
21	Clerical & General Office Expenses	0	0	528,654	0	0	0	0	0	0	0	0	528,654	21
22	Employee Benefits & Payroll Taxes	0	0	53,238	0	0	0	0	0	0	0	0	53,238	22
23	Inservice Training & Education	0	(72)	1,674	0	0	0	0	0	0	0	0	1,602	23
24	Travel and Seminar	(6,687)	0	6,611	0	0	0	0	0	0	0	0	(76)	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	88,195	0	0	0	0	0	0	0	0	88,195	26
27	Other (specify):*	11,290	0	0	0	0	0	0	0	0	0	0	11,290	27
28	**TOTAL General Administration**	(37,179)	(425,470)	700,625	0	0	0	0	0	0	0	0	237,976	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(37,179)	(451,173)	773,996	0	0	0	0	0	0	0	0	285,644	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Peru # 0048090 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	248,774	0	29,800	0	0	0	0	0	0	0	278,574	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,762)	113,383	0	3,345	0	0	0	0	0	0	0	111,966	32
33	Real Estate Taxes	0	54,666	0	0	0	0	0	0	0	0	0	54,666	33
34	Rent-Facility & Grounds	0	(565,020)	0	9,175	0	0	0	0	0	0	0	(555,845)	34
35	Rent-Equipment & Vehicles	0	0	0	16,243	0	0	0	0	0	0	0	16,243	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(4,762)	(148,197)	0	58,563	0	0	0	0	0	0	0	(94,396)	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	213,203	0	239	0	0	0	0	0	0	0	213,442	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	213,203	0	239	0	0	0	0	0	0	0	213,442	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(41,941)	(386,167)	773,996	58,802	0	0	0	0	0	0	0	404,690	45

Facility Name & ID Number Heritage Health Peru # 0048090 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
Monroe SNF Services LLC	100	Attached Following This Page		Heritage Operations G	Bloomington	Mgmt. Services
				Green Tree Pharmacy	Minonk	Pharmacy
				Heritage Manor Real E	Bloomington	Propert rental

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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		$ (25,703)	$ (25,703)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy		(72)	(72)	2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy		213,203	213,203	3
4	V	19	Adjustment for Related Organization	425,398	Heritage Operations Group, LLC			(425,398)	4
5	V								5
6	V	34	Adjustment for Related Organization	565,020	Heritage Manor Real Estate, LLC			(565,020)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		54,666	54,666	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		106,947	106,947	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		248,774	248,774	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		6,436	6,436	10
11	V								11
12	V								12
13	V								13
14	Total			$ 990,418			$ 604,251	$ * (386,167)	14

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

Facility Name & ID Number Heritage Health Peru # 0048090 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Heritage Operations Group		$ 6,196	$ 6,196	15
16	V	2	Food Purchase		Heritage Operations Group		(22)	(22)	16
17	V	3	Housekeeping		Heritage Operations Group		8,261	8,261	17
18	V	4	Laundry		Heritage Operations Group		590	590	18
19	V	5	Heat & Other Utilities		Heritage Operations Group		1,967	1,967	19
20	V	6	Maintenance		Heritage Operations Group		24,108	24,108	20
21	V	7	Other		Heritage Operations Group		0	0	21
22	V	9	Medical Director		Heritage Operations Group		0	0	22
23	V	10	Nursing & Medical Records		Heritage Operations Group		32,087	32,087	23
24	V	11	Activities		Heritage Operations Group		7	7	24
25	V	12	Social Service		Heritage Operations Group		177	177	25
26	V	13	Nurse Aide Training		Heritage Operations Group		0	0	26
27	V	14	Program Transportation		Heritage Operations Group		0	0	27
28	V	15	Other		Heritage Operations Group		0	0	28
29	V	17	Administrative		Heritage Operations Group		0	0	29
30	V	18	Directors Fees		Heritage Operations Group		0	0	30
31	V	19	Professional Services		Heritage Operations Group		21,033	21,033	31
32	V	20	Fees, Subscription, Promotions		Heritage Operations Group		1,220	1,220	32
33	V	21	Clerical & General Office Expenses		Heritage Operations Group		528,654	528,654	33
34	V	22	Employee Benefits & Payroll Taxes		Heritage Operations Group		53,238	53,238	34
35	V	23	Inservice Training & Education		Heritage Operations Group		1,674	1,674	35
36	V	24	Travel and Seminar		Heritage Operations Group		6,611	6,611	36
37	V	25	Other Admin. Staff Transportation		Heritage Operations Group		0	0	37
38	V	26	Insurance-Prop.Liab.Malpract		Heritage Operations Group		88,195	88,195	38
39	Total			$			$ 773,996	$ * 773,996	39

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

Facility Name & ID Number Heritage Health Peru # 0048090 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27		$	Heritage Operations Group		$ 0	$ 0	15
16	V	30			Heritage Operations Group		29,800	29,800	16
17	V	31			Heritage Operations Group		0	0	17
18	V	32			Heritage Operations Group		3,345	3,345	18
19	V	33			Heritage Operations Group		0	0	19
20	V	34			Heritage Operations Group		9,175	9,175	20
21	V	35			Heritage Operations Group		16,243	16,243	21
22	V	36			Heritage Operations Group		0	0	22
23	V	38			Heritage Operations Group		0	0	23
24	V	39			Heritage Operations Group		239	239	24
25	V	40			Heritage Operations Group		0	0	25
26	V	41			Heritage Operations Group		0	0	26
27	V	42			Heritage Operations Group		0	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			$			$ 58,802	$ * 58,802	39

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

Facility Name & ID Number Heritage Health Peru # 0048090 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Heritage Health Peru # 0048090 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	127	$ 6,196	1
2	2	Food Purchase	Beds	2,493	25	(423)	0	127	(22)	2
3	3	Housekeeping	Beds	2,493	25	162,156	0	127	8,261	3
4	4	Laundry	Beds	2,493	25	11,591	0	127	590	4
5	5	Heat & Other Utilities	Beds	2,493	25	38,605	0	127	1,967	5
6	6	Maintenance	Beds	2,493	25	473,233	88,567	127	24,108	6
7	7	Other	Beds	2,493	25	0	0	127	0	7
8	9	Medical Director	Beds	2,493	25	0	0	127	0	8
9	10	Nursing & Medical Records	Beds	2,493	25	629,872	35,401	127	32,087	9
10	11	Activities	Beds	2,493	25	129	0	127	7	10
11	12	Social Service	Beds	2,493	25	3,478	3,478	127	177	11
12	13	Nurse Aide Training	Beds	2,493	25	0	0	127	0	12
13	14	Program Transportation	Beds	2,493	25	0	0	127	0	13
14	15	Other	Beds	2,493	25	0	0	127	0	14
15	17	Administrative	Beds	2,493	25	0	0	127	0	15
16	18	Directors Fees	Beds	2,493	25	0	0	127	0	16
17	19	Professional Services	Beds	2,493	25	412,869	0	127	21,033	17
18	20	Fees, Subscription, Promotions	Beds	2,493	25	23,945	0	127	1,220	18
19	21	Clerical & General Office Expense	Beds	2,493	25	10,377,428	9,978,005	127	528,654	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,493	25	1,045,059	0	127	53,238	20
21	23	Inservice Training & Education	Beds	2,493	25	32,865	0	127	1,674	21
22	24	Travel and Seminar	Beds	2,493	25	129,776	0	127	6,611	22
23	25	Other Admin. Staff Transportatio	Beds	2,493	25	0	0	127	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,493	25	1,731,253	0	127	88,195	24
25	TOTALS					$ 15,193,470	$ 10,226,789		$ 773,996	25

Facility Name & ID Number Heritage Health Peru # 0048090 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

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 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	$	$	127	$	1
2	30	Depreciation	Beds	2,493	25	584,981		127	29,800	2
3	31	Amortization of Pre-Op & Org	Beds	2,493	25			127		3
4	32	Interest	Beds	2,493	25	65,658		127	3,345	4
5	33	Real Estate Taxes	Beds	2,493	25			127		5
6	34	Rent-Facility & Grounds	Beds	2,493	25	180,106		127	9,175	6
7	35	Rent-Equipment & Vehicles	Beds	2,493	25	318,843		127	16,243	7
8	36	Other	Beds	2,493	25			127		8
9	38	Medically Nec Transportation	Beds	2,493	25			127		9
10	39	Ancillary Service Centers	Beds	2,493	25	4,685		127	239	10
11	40	Barber and Beauty Shops	Beds	2,493	25			127		11
12	41	Coffee and Gift Shops	Beds	2,493	25			127		12
13	42	Other	Beds	2,493	25			127		13
14										14
15										15
16										16
17										17
18										18
19						9,978,005				19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 11,132,278	$		$ 58,802	25

Facility Name & ID Number Heritage Health Peru # 0048090 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			$	$			$ 106,947	1
2	Busey Bank		xx	Loan Fee Amortization							6,436	2
3												3
4												4
5												5
	Working Capital											
6	Busey Bank		xx	Working Capital							63,680	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 177,063	9
	B. Non-Facility Related*											
10	Interest Income										(4,762)	10
11												11
12	Allocated Corporate										3,345	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,417)	14
15	TOTALS (line 9+line14)						$	$			$ 175,646	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 Peru # 0048090 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

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

Description		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	54,666	2
3. Under or (over) accrual (line 2 minus line 1).	$	54,666	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.	$	54,666	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2015	50,571	8
2016	54,500	9
2017	54,160	10
2018	54,662	11
2019	54,666	12

FOR BHF USE ONLY

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

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Health Peru COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0048090

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.	1709312014		$ 51,984.38	$ 51,984.00
2.	1709312013		$ 2,681.84	$ 2,682.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 54,666.22	$ 54,666.00

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Heritage Health Peru # 0048090 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,520 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1988	$ 50,000	1
2					2
3	TOTALS			$ 50,000	3

Facility Name & ID Number Heritage Health Peru # 0048090 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	127				$ 391,963	$		$	$	$	4
5					325,293						5
6					153,474						6
7					677,402						7
8											8
	Improvement Type**										
9	1978 Improvements			1978	6,059						9
10	1979 Improvements			1979	9,952						10
11	1980 Improvements			1980	28,648						11
12	1981 Improvements			1981	8,175						12
13	1982 Improvements			1982	39,938						13
14	1983 Improvements			1983	13,985						14
15	1984 Improvements			1984	19,793						15
16	1985 Improvements			1985	550						16
17	1986 Improvements			1986	22,120						17
18	1988 Improvements			1988	19,053						18
19	1989 Improvements			1989	25,453						19
20	1990 Improvements			1990	12,118						20
21	1991 Improvements			1991	19,157						21
22	1992 Improvements			1992	87,224						22
23	1993 Improvements			1993	43,270						23
24	1994 Improvements			1994	16,885						24
25	1995 Improvements			1995							25
26	1996 Improvements			1996	13,024						26
27	1997 Improvements			1997	296,841						27
28	1998 Improvements			1998	20,635						28
29	1999 Improvements			1999	85,772						29
30	2000 Improvements			2000	16,434						30
31	2001 Improvements			2001	9,167						31
32	2002 Improvements			2002	10,187						32
33											33
34	C/O Allocation					29,800		29,800			34
35	Book Depreciation					227,283		227,283			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 Peru # 0048090 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	$ 13,789	$		$	$	$	37
38	2004 Improvements	2004	29,449						38
39	2005 Improvements	2005	83,170						39
40	2006 Improvements	2006	55,277						40
41	2007 Improvements	2007	286,795						41
42	2008 Improvements	2008	59,381						42
43	2009 Improvements	2009	1,007,348						43
44	2010 Improvements	2010	722,961						44
45	2011 Improvements	2011	42,280						45
46	2012 Improvements	2012	17,509						46
47	2013 Improvements	2013	181,269						47
48	2014 Improvements	2014	47,860						48
49									49
50	Circuit and wire installation for wall mounted heaters	2015	5,820						50
51	New air condensing unit - middle hallway	2015	4,628						51
52	New air handler (5 ton) - entry way	2015	5,387						52
53	Replace sewer line	2015	37,614						53
54	Radiator replacement	2015	3,624						54
55	Install 100 gallon water heater	2015	7,980						55
56	Replace sewer pipe and foundation wall	2015	6,580						56
57	Cabling - 30 Cat 6 to data room	2015	15,610						57
58									58
59	Install hot water storage tank	2016	10,291						59
60	Replace fire alarm wiring	2016	3,984						60
61	Repair sewer and concrete walkway	2016	9,798						61
62									62
63	Added (2) water cabinet heaters to therapy room and (9)	2017	29,286						63
64	cabinet heaters to various hallways throughout the facility								64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,060,262	$ 257,083		$ 257,083	$	$	70

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

Facility Name & ID Number Heritage Health Peru # 0048090 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		$ 5,060,262	$ 257,083		$ 257,083	$	$	1
2									2
3	Added circulating pump to Boiler #1	2018	2,616						3
4	Installed heat detectors	2018	5,455						4
5	Installed addressable devices and circuits	2018	9,847						5
6									6
7	Install expoxy coating to shower room floors	2019	11,587						7
8	Replace backflow valves	2019	6,997						8
9									9
10	Replace gutters - East Courtyard	2020	5,260						10
11	Replace HVAC Condenser - East & West Short Hallways	2020	17,057						11
12	Install 4 ton condensing unit - Dining Room	2020	3,644						12
13	Replace rooftop exhaust fans over restrooms and common area	2020	20,117						13
14	Replace water heater	2020	11,832						14
15	Replace dry system piping	2020	6,350						15
16									16
17									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	TOTAL (lines 1 thru 33)		$ 5,161,024	$ 257,083		$ 257,083	$	$	34

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

Facility Name & ID Number: Heritage Health Peru # 0048090 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	$ 1,713,038	$ 21,491	$ 21,491	$		$	71
72	Current Year Purchases	23,097						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,736,135	$ 21,491	$ 21,491	$		$	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)	$ 6,947,159	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 278,574	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 278,574	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 Peru # 0048090 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: $ 38,215 Description: Televisions and 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 Peru # 0048090 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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 Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 472,705	$		$ 472,705	1
2	Licensed Speech and Language Development Therapist		hrs			47,647			47,647	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			450,438	0		450,438	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				287,587		287,587	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					136,511			136,511	13
14	TOTAL			$		$ 1,107,301	$ 287,587		$ 1,394,888	14

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

Facility Name & ID Number Heritage Health Peru # 0048090 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,144	$	1
2	Cash-Patient Deposits	28,865		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	(189,709)		3
4	Supply Inventory (priced at FIFO)	13,788		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,442		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(257,347)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (401,817)	$	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)**	$ (401,817)	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,865		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	299,175		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,123		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	12,535		36
37	Deferred Stimulus	234,782		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 593,480	$	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)**	$ 593,480	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (995,297)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (401,817)	$	48

*(See instructions.)

Facility Name & ID Number Heritage Health Peru # 0048090 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**	$ (779,491)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (779,491)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(215,806)	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)**	$ (215,806)	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)**	$ (995,297)	24 *

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

Facility Name & ID Number Heritage Health Peru # 0048090 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	$ 7,566,682	1
2	Discounts and Allowances for all Levels	(2,663,957)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,902,725	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,562,765	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,562,765	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	667,129	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	524,431	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	650	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,192,210	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,762	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,762	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)**	$ 8,662,462	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,321,700	31
32	Health Care	3,994,538	32
33	General Administration	1,919,021	33
	B. Capital Expense		
34	Ownership	670,346	34
	C. Ancillary Expense		
35	Special Cost Centers	972,663	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)***	$ 8,878,268	40
41	**Income before Income Taxes (line 30 minus line 40)****	(215,806)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (215,806)	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 Peru # 0048090 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	1,985	2,068	$ 77,339	$ 37.40	1
2	Assistant Director of Nursing	2,084	2,171	61,966	28.54	2
3	Registered Nurses	24,331	25,344	753,404	29.73	3
4	Licensed Practical Nurses	21,359	22,249	567,511	25.51	4
5	CNAs & Orderlies	91,779	95,603	1,515,580	15.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,913	4,076	85,557	20.99	8
9	Activity Director					9
10	Activity Assistants	8,021	8,355	160,216	19.18	10
11	Social Service Workers	3,263	3,399	70,604	20.77	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,893	21,763	271,797	12.49	15
16	Dishwashers					16
17	Maintenance Workers	8,677	9,038	150,069	16.60	17
18	Housekeepers	11,220	11,688	123,558	10.57	18
19	Laundry	3,304	3,442	40,481	11.76	19
20	Administrator	2,002	2,085	101,194	48.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,640	13,167	327,268	24.86	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)	215,471	224,448	$ 4,306,544 *	$ 19.19	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		$ 8,169	L1 C3	35
36	Medical Director		28,421	L9 C3	36
37	Medical Records Consultant		614	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		7,231	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		1,845	L12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 46,280		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses		0		51
52	Certified Nurse Assistants/Aides		6,523	L10 C3	52
53	TOTAL (lines 50 - 52)		$ 6,523		53

Facility Name & ID Number Heritage Health Peru # 0048090 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lori Walsh	Administrator		$ 101,194
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 101,194

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	$ 430,209
Legal adj to Zero		12,880
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 443,089

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 33,470
Unemployment Compensation Insurance	13,021
FICA Taxes	329,451
Employee Health Insurance	220,819
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	75,790
Central Office Allocation	53,238
TOTAL (agree to Schedule V, line 22, col.8)	$ 725,789

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	4,400
Health Care Worker Background Check (Indicate # of checks performed)	2,283
Patient Background Checks	
PR	12,050
Dues & Subscriptions	10,607
License & Fees	273
Central Office Allocation	1,220
Less: Public Relations Expense	(12,050)
Non-allowable advertising	(6,162)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,621

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	4,615
	35
Seminar Expense	425
	(76)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,999

**See instructions.

Facility Name & ID Number Heritage Health Peru # 0048090 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 - $8,889**

(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. $ **231,847**
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. $ **445**

(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 2 Line #	Sch 5 pg 2 Col #	Sch 6 pg 4 Line #	Adjustment Amount	
1000		PETTY CASH	1,144						
1010		CASH IN BANK							
1040		CASH IN BANK-PAYROLL							
1100		ACCOUNTS RECEIVABLE	-189,709						
1110		MEDICARE RECEIVABLES							
1125		IPA INCOME RECEIVABLE							
1130		MEDICARE COST REPORT							
1132		US HHS STIMULUS SETTLEME	-234,782						
1140		UNAPPLIED CASH RECEIPTS							
1145		A/R SUSPENSE REFUNDS							
1190		ACCRUED INTEREST REC							
1200		PREPAID INSURANCE	1,442						
1220		OTHER PREPAID EXPENSES							
1300		FOOD INVENTORY	13,788						
1310		SUPPLIES INVENTORY							
1400		LAND	0						
1450		FURNITURE & EQUIPMENT	0						
1460		ACCUM DEPR-FURN & EQUIP	0						
1475		BUILDING & IMPROVEMENTS	0						
1490		ACCUM DEPR-BUILDING	0						
1530		RESIDENT FUNDS	26,865						
1550		LOAN FEES	0						
1560		REAL ESTATE TAX ESCROW							
1575		REIMBURSABLE PURCHASES							
1850		INTERCOMPANY	-257,347						
2010		ACCOUNTS PAYABLE	0						
2095		BONUSES PAYABLE							
2100		ACCRUED PAYROLL	-56,639						
2110		ACCRUED VACATION PAY	-242,539						
2120		UC TAXES PAYABLE							
2125		FICA TAX PAYABLE	-18,123	-18,123					
2130		FIT PAYABLE							
2140		STATE W/H PAYABLE		0					
2145		EARNED INCOME CREDIT							
2150		UC FED CREDIT REDUCTION							
2220		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	-12,535						
2350		REAL ESTATE TAX PAYABLE	0						
2385		ACTIVITY FUND	0						
2390		SECURITY DEPOSITS	0						
2391		VOLUNTEER FUND							
2393		HEART FUND/AIZAWR							
2395		DEFERRED INC EMP & MEM							
2400		CURRENT PORTION LT DEBT							
2460		INCOME TAXES PAYABLE							
2512		DUE TO RESIDENTS	-26,865						
2600		MORTGAGE PAYABLE	0						
2650		EQUIPMENT LOAN PAYABLE							
2695		CURRENT PORTION LT DEBT							
2696		DEFERRED INCOME TAXES							
2710		COMMON STOCK							
2720		RETAINED EARNINGS	779,461						
2970		PROFIT/LOSS FOR PERIOD	215,806						
3007.1		PATIENT DAYS-PRIVATE	5,664						
3007.2		PATIENT DAYS-IPA	20,019						
3007.3		PATIENT DAYS-MEDICARE	4,301						
3007.4		PATIENT DAYS-CONVERSION							
3007.5		PATIENT DAYS-LICENSED							
3007.6		PATIENT DAYS-TOTAL							
3010		1 BASIC CHARGE-PRIVATE & VA	-7,466,430		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	-127,196		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	-324,431		0	0	0	0	
3101		17 DRUGS-OTHER							
3110		6 PT-PRIVATE	-2,562,765		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	162,124		0	0	0	0	
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	2,663,957		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	-667,129		40	0	0	0	
3520		16 RENT INCOME	0		0	0	0	0	
3530		13 BEAUTY SHOP	0		0	0	0	0	
3560		12 ACTIVITY FUND INCOME	0		0	0	0	0	
3570		12 VENDING INCOME/EXPENSE	-646		0	0	0	0	
3580		7 MANAGEMENT FEES			0	0	0	0	
3590		1 EQUIPMENT RENTAL	26,944		0	0	0	0	
3595		21 RESIDENT TRANSPORTATION	0		0	0	0	0	
3600		21 MISC INCOME	-4		0	0	0	0	
4110		GENERAL & ADMINIST WAGES	298,392	327,268	21	1	17	0	
4111		ADMINISTRATOR WAGES	101,194	101,194	17	1	0	0	
4115		VACATION & SICK - G&A	28,876		21	1	0	0	
4120	4475	EMPLOYEE BENEFITS	69,928	672,551	22	3	0	0	
4125		EMPLOYEE HEPETITIS VACCIN	0		22	3	0	0	
4130		EMPLOYEE SCHOLARSHIP WA	7,612	162,124	21	1	0	0	
4135		EMPLOYEE SCHOLARSHIP CC	-1,750		23	3	0	0	
4220		DIRECTORS FEES	0	0	18	3	0	0	
4250	4255	OFFICE SUPPLIES	30,981	30,981	21	2	0	0	
4260		TELEPHONE	8,718	8,718	21	3	0	0	
4275		TRAINING & EMPLOYEE DEVL	162	162	23	3	16	0 **	
4280		GENERAL TRAVEL	4,615	5,075	24	3	16	0	
4281		MEAL EXPENSE FOR TRAVEL	35		24	3	19	0	
4285		EDUCATION & SEMINAR	425		24	3	19	-6,687 ***	
4290		HELP WANTED ADVERTISING	4,400	110,026	20	3	0	0	-69,723
4291		PROMOTIONAL ADVERTISING	10,690		20	3	25	-10,690	
4292		PUBLIC RELATIONS	12,050		20	3	25	-12,050	
4300		LICENSES & FEES	69,996		20	3	17	0	
4310		DUES & SUBSCRIPTIONS	10,607		20	3	17	-6,162	
4320		CONTRIBUTIONS	0		27	3	20	0	
4350		PROFESSIONAL FEES	17,691	443,089	19	3	22	-12,880	
4355		MEDICAL DIRECTOR	28,421	28,421	9	3	0	0	
4360		UTILIZATION REVIEW	0		10	3	0	0	
4361		OTHER PHYSICIAN FEES			39	3	0	0	
4362		MEDICAL RECORDS CONSULT	614		10	3	0	0	
4363		PHARMACIST FEES	7,231		10	3	0	0	
4364		SOC SERV/ACT CONSULT	1,845	1,845	12	3	0	0	
4370		TV RENTAL	17,750		35	3	5	0	
4380		INCOME TAXES		-11,129	27	3	26	0	
4383		BACKGROUND CHECKS	2,283		20	3	26	0	
4400		PAYROLL TAXES	342,472		22	3	0	0	
4401		PAYROLL TAXES ADMINIST	0		22	3	0	0	
4410		GROUP INSURANCE	220,819		22	3	0	0	
4420		LIABILITY INSURANCE	68,962	68,962	26	3	0	0	
4425		INSURANCE-OWNERS			22	3	21	0	
4430		WORKMENS COMP INSURANC	33,470		22	3	0	0	
4450		CENTRAL OFFICE FEES	425,398		19	3	34	0 **	
4460		BAD DEBTS	-12,390		27	3	24	12,390	
4470		LOST ITEMS-RESIDENTS	161		27	3	0		
4490		MISCELLANEOUS	0		27	3	0	0	
4510		REAL ESTATE TAXES	0	0	33	3	0	0	
4600		LEASED EQUIPMENT	20,465	38,215	35	3	16	0	
5110		MAINTENANCE SALARIES	138,251	150,069	6	1	0	0	
5120		MAINTENANCE SICK & VAC	11,818		6	1	0	0	
5130		ELECTRIC	63,940	119,299	5	3	0	0	
5131		NATURAL GAS	26,071		5	3	0	0	
5132		HEATING & DEISEL OIL			5	3	0	0	
5133		WATER & SEWER	29,288		5	3	0	0	
5134		TRASH COLLECTION	43,785	136,393	6	3	0	0	
5140		PROPERTY PLANT REPLACEM	19,430	109,668	6	2	0	0	
5160		GENERAL REPAIR & MAINT	90,238		6	2	0	0	
5165		MAINTENANCE CONTRACTS	92,608		6	3	0	0	
5210		DIETARY WAGES	251,999	271,797	1	1	0	0	
5220		DIETARY SICK & VAC	19,798		1	1	0	0	
5240		DIETARY CONSULTANT	8,169	8,169	2	3	13	0	
5248		FOOD PURCHASES	272,841	272,396	2	2	0	0	
5250		SUPPLIES-DISHWASHING	2,862	22,859	1	2	0	0	
5260		DIETARY REPLACEMENT	645		1	2	0	0	
5270		KITCHEN SUPPLIES-PAPER	19,352		1	2	0	0	
5295		MEAL CREDIT	-445		2	2	0	0	
5310		LAUNDRY WAGES	36,894	40,481	4	1	0	0	
5340		LAUNDRY SICK & VAC	3,587		4	1	0	0	
5370		LAUNDRY REPLACEMENT	7,095	9,485	4	2	0	0	
5380		LAUNDRY REIMBURSEMENT			4	3	0	0	
5390		LAUNDRY SUPPLIES	2,390		4	2	0	0	
5410		HOUSEKEEPING WAGES	115,789	123,558	3	1	0	0	
5440		HOUSEKEEPING SICK & VAC	7,769		3	1	0	0	
5480		HOUSEKEEPING SUPPLIES	57,526	57,526	3	2	0	0	
5490		HOUSEKEEPING SUPPLIES-PF	0		3	2	0	0	
6010		RN WAGES-MEDICARE		3,061,357	10	1	0	0	
6020		RN WAGES-NON MEDICARE	695,534		10	1	0	0	
6030		DON WAGES	77,339		10	1	0	0	
6035		ADON	61,966		10	1	0	0	
6040		RN SICK & VACATION	57,870		10	1	0	0	
6110		LPN WAGES-MEDICARE	523,757		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	43,754		10	1	0	0	
6210		AIDE WAGES-MEDICARE			10	1	0	0	
6220		AIDE WAGES-NON MEDICARE	1,423,391		10	1	0	0	
6230		WARD CLERKS			10	1	0	0	
6240		AIDE VACATION & SICK	92,189		10	1	0	0	
6245		CONTRACT NURSES-RN	0		10	3	0	0	
6246		CONTRACT NURSES-LPN	0		10	3	0	0	
6247		CONTRACT NURSES-AIDES	6,523		10	3	0	0	
6250		NURSE AIDE TRAINING WAGES	0	0	13	1	0	0	
6255		NURSE AID TRAINING EXP	0	0	13	2	0	0	
6260		NURSE AIDE TRAINING REIMB	0		0	0	0	0	
6270		REHAB WAGES	81,366		10	1	0	0	
6275		REHAB SICK & VAC	4,191		10	1	0	0	
6280		NURSING DEPT EDUCATION			23	3	0	0	
6290		NURSING SUPPLIES	24,362	232,360	10	2	0	0	
6295		NURSING SUPPLIES	206,686		10	2	0	0	
6390		REPLACEMENT-NURSING	1,312		10	2	0	0	
6490		NURSING OTHER	0	14,368	10	3	0	0	
7280		DRUG PURCHASES	287,587	287,587	39	2	0	0 ***	
7281		DRUG PURCHASES-OTHER	0		39	2			
7380		LABORATORY SERVICES	136,511	136,511	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	139,352	160,216	11	1	0	0	
7540		ACTIVITIES SICK & VAC	20,864		11	1	0	0	
7590		ACTIVITIES SUPPLIES	1,269	1,269	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	450,438	970,790	39	3	0	0 ***	
7660		PT SUPPLIES	0		39	2	0	0	
7710		SOCIAL SERVICE WAGES	64,864	70,604	12	1	0	0	
7720		SOCIAL SERVICE SICK & VAC	5,740		12	1	0	0	
7730		SOCIAL SERVICE EXPENSES	0	0	12	2	0	0	
7740		OT FEE	472,705		39	3	0	0 ***	
7750		SOCIAL THERAPIST FEE	0	0	12	3	0	0	
7770		SPEECH THERAPY FEE	47,647		39	3	0	0 ***	
7800		BEAUTICIAN WAGES		0	40	1	0	0	
7810		BEAUTICIAN SICK & VAC			40	1	0	0	
7820		BEAUTICIAN FEES	1,873	1,873	40	3	0	0	
7890		BEAUTY SHOP SUPPLIES	0	0	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	568,451	568,451	34	3	0	0	
8120		INTEREST EXPENSE	63,680	63,680	32	3	14	-4,762	
8130		DEPRECIATION	0	0	30	3	9	0	
8150		LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510		INTEREST INCOME	-4,762		32	0	10	0	
9520		MISC NON-OPERATING INCOM	0		0	0	0	0	
9700		INCOME TAXES	1,100		0	0	0	-1,100	
			8,711,382	8,878,268					
				166,886					
GRAND TOTALS			215,806					-41,941	
			(NET INCOME)						
			0						

FACILITY NAME:

FACILITY ID: 0

FACILITY UNITS: 162

BALANCE SHEET TOTAL 0

Code	Account	Description	Amount
1,000	1,000	CASH	1,144
1,100	1,100	ACCTS R	62,925
1,101	1,101	ALLOW. F	(252,214)
1,110	1,110	ACCTS RECEIV-MC	
1,125	1,125	ACCTS RECEIV-IPA	
1,132	1,132	US HHS S	(234,782)
1,140	1,140	UNAPPLIED CASH RECEIPTS	
1,145	1,145	A/R SUSPENSE REFUNDS	
1,200	1,200	PREPAID	
1,220	1,220	OTHER P	1,442
1,300	1,300	DIETARY	13,788
1,310	1,310	SUPPLIES INVENTORY	
1,320	1,320	LINEN INVENTORY	
1,400	1,400	LAND	0
1,450	1,450	FURNITUF	0
1,460			0
1,475	1,475	BUILDING	0
1,490	1,490	ACCUM D	0
1,530	1,530	RESIDEN	26,865
1,550	1,550	LOAN FEI	0
1,551	1,551	LOAN FEES ADDED	
1,850	1,850	INTERCO	(257,347)
2,010	2,010	ACCOUNT	0
2,095	2,095	BONUSES PAYABLE	
2,100	2,100	ACCRUEI	(56,639)
2,100	2,100	PR CLEARING-BENEFITS	
2,100	2,100	PR CLEARING-LABOR	
2,110	2,110	ACCRUEI	(242,539)
2,120	2,120	U.C. TAXE	0
2,125	2,125	FICA TAXE	(18,123)
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	EMPLOYEES 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	ACCRUEI	0
2,320	2,320	IPA PAYM	(12,535)
2,350	2,350	REAL EST	0
2,385			
2,400	2,400	CURRENT PORTION OF LT DEBT	
2,512	2,512	DUE TO R	(26,865)
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	RETAINEI	779,461
		net income	215,806
		balance	0

Code	Account	Description	Amount
3,007	3,007	PATIENT I	5,664
3,007	3,007	PATIENT I	20,019
3,007	3,007	PATIENT I	4,301
3,007			0
3,007			
3,007			
3,007			
3,010	3,010	BASIC CH	(7,466,430)
3,020	3,020	BASIC CH	0
3,030	3,030	BASIC CH	0
3,040		ASSESSM	162,124
3,050			0
3,060			0
3,061			0
3,080	3,080	NURSING	(127,196)
3,081	3,081	NURSING	0
3,082	3,082	NURSING	0
3,083	3,083	NURSING	0
3,100	3,100	DRUGS-M	(324,431)
3,101			0
3,110	3,110	PHYSICAL	(2,562,765)
3,111			0
3,112	3,112	PHYSICAL	0
3,113	3,113	PHYSICAL	0
3,140	3,140	LABORATORY INCOME	
3,150			0
3,151			
3,152	3,152	ST/OT THI	0
3,153	3,153	ST/OT THI	0
3,180	3,185	REHAB/ISOLATION/OTHER CHG	
3,410	3,410	IPA/OTHEI	0
3,411	3,411	MEDICARE	0
3,420	3,420	MEDICARE	2,546,160
3,452	3,452	HHS STIM	(667,129)
3,520	3,520	RENT INC	0
3,530	3,530	BEAUTY S	0
3,560			0
3,570	3,570	VENDING	(646)
3,590	3,590	EQUIPMEI	26,944
3,595	3,595	RESIDENT	0
3,600	3,600	MISC INC	(4)
4,110	4,110	G&A WAG	298,392
4,111	4,111	ADMINISTI	101,194
4,115	4,115	G&A PTO	28,876
4,120	4,120	EMPLOYE	70,071
4,121			0
4,130	4,130	EMPLOYE	7,612
4,135	4,135	EMPLOYE	(1,750)
4,250	4,250	OFFICE SI	8,460
4,255	4,255	POSTAGE	4,906
4,260	4,260	TELEPHO	8,718
4,275	4,275	TRAINING	162
4,276			0
4,280	4,280	GENERAL	4,615
4,281	4,281	MEAL EXP	35
4,285	4,285	EDUCATIC	425
4,289	4,289	MEETINGS	0
4,290	4,290	HELP WAI	4,400
4,291	4,291	PROMOTI	10,690
4,292	4,292	PUBLIC RI	12,050
4,300	4,300	LICENSE &	69,996
4,310	4,310	DUES & S	10,607
4,320	4,320	CONTRIBI	0
4,350	4,350	PROFESS	17,691
4,355	4,355	MEDICAL I	28,421
4,362			614
4,363			7,231
4,364	4,364	SOCIAL SI	1,845
4,370	4,370	TV RENTA	17,750
4,383	4,383	BACKGRC	2,283
4,390	4,390	OTHER T/	1,100
4,400	4,400	PAYROLL	342,472
4,401	4,401	PAYROLL	0
4,410	4,410	GROUP IN	220,819
4,420	4,420	LIABILITY I	68,962
4,430	4,430	WORKMAI	31,996
4,435	4,435	W/C-FIRS	0
4,436	4,436	DRUG TES	1,474
4,450	4,450	MANAGEM	425,398
4,460	4,460	BAD DEBT	(12,390)
4,461	4,461	BAD DEBT	115,792
4,470	4,470	LOST ITEI	161
4,475	4,475	UNIFORM	(143)
4,486	4,486	SERVICE (	82,874
4,490	4,490	MISC EXPI	443
4,496	4,496	MISC. M.I.S	17,615
4,510	4,510	REAL EST	0
4,600	4,600	LEASED E	20,465
5,110	5,110	MAINTENA	138,251
5,120	5,120	MAINTENA	11,818
5,130	5,130	ELECTRIC	63,940
5,131	5,131	NATURAL	26,071
5,133	5,133	WATER &	29,288
5,134	5,134	TRASH CC	43,785
5,140	5,140	PROP/PLA	19,430
5,160	5,160	GENERAL	90,238
5,165	5,165	MAINTENA	9,734
5,210	5,210	DIETARY \	251,999
5,220	5,220	DIETARY I	19,798
5,248	5,248	FOOD PUI	272,398
5,250	5,250	SUPPLIES	2,862
5,260	5,260	REPLACE	645
5,270	5,270	KITCHEN S	19,352
5,295	5,295	MEAL INCO	(445)
5,310	5,310	LAUNDRY	36,894
5,340	5,340	LAUNDRY	3,587
5,370	5,370	REPLACE	7,095
5,230	5,230	DIETARY (	8,169
5,390	5,390	LAUNDRY	2,390
5,410	5,410	HOUSEKE	115,789
5,440	5,440	HOUSEKE	7,769
5,480	5,480	SUPPLIES	57,526
5,490	5,490	SUPPLIES	0
6,020	6,020	RN WAGE	695,534
6,030	6,030	DON WAG	77,339
6,035	6,035	ADON WA	61,966
6,040	6,040	RN PTO &	57,870
6,120	6,120	LPN WAGI	523,757
6,140	6,140	LPN PTO &	43,754
6,220	6,220	AIDES WA	1,423,391
6,240	6,240	AIDES PTO	92,189
6,245		RN CONTI	0
6,246		LPN CONT	0
6,247		AIDES CO	6,523
6,250			0
6,255			0
6,260			0
6,270	6,270	REHAB W.	81,366
6,275	6,275	REHAB PT	4,191
6,290	6,290	NURSING	24,362
6,295	6,295	NURSING	206,686
6,390	6,390	REPLACE	1,312
6,490	6,490	OTHER	0
7,280	7,280	DRUG PUI	287,587
7,281	7,281	DRUG PUI	0
7,380	7,380	LABORATI	100,469
7,391	7,390	X-RAY SEI	26,136
7,393			9,906
7,510	7,510	ACTIVITIES	139,352
7,540	7,540	ACTIVITIES	20,864
7,590	7,590	ACTIVITIES	1,269
7,620	7,620	PHYSICAL	450,438
7,660	7,660	P.T. SUPP	0
7,710	7,710	SOCIAL SI	64,864
7,720	7,720	SOCIAL SI	5,740
7,730	7,730	SOCIAL SI	0
7,740	7,740	OCCUPAT	472,705
7,750			
7,770	7,770	SPEECH T	47,647
7,820	7,820	BEAUTICI/	1,873
7,890			0
7,960			0
8,120	8,120	INTEREST	1,976
8,125			61,704
8,130	8,130	DEPRECI/	0
8,150			0
9,510	9,510	INTEREST	(4,762)
9,520	9,520	MISC NON	0
9,530	4,220		0
	8,100		568,451
	9,702		0
	5,230		0
			215,806

Expenses Fixed Assets 0

Heritage Manor - Peru
IDPH ID# 48090
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	$	287,587
Purchased Hospital Services		29,369
Purchased Laboratory Services		100,469
Purchased Radiology Services		6,673
Amount Reclassified to Line 39	$	424,098

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

Line Item		
Provider Participation Fee - $1.50	$	(69,723)
Provider Assesment Fee - $6.07		(162,124)
	$	(231,847)
Provider Participation Fee	$	231,847

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

Line Item		
Pharmacy Consulting Fee	$	7,231