		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: 0053421

Facility Name: Heritage Health Robinson

Address: 600 E Robinwood Dr (Number) Robinson (City) 62454 (Zip Code)

County: Crawford

Telephone Number: (618) 544-3192 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: 2015

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) David M Underwood
(Title) EVP & CFO

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

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

Facility Name & ID Number Heritage Health Robinson # 0053421 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	67	Skilled (SNF)	67	24,522	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	67	TOTALS	67	24,522	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,694	6,121	1,752	17,567	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,694	6,121	1,752	17,567	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.64%

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 2015

J. Was the facility purchased or leased after January 1, 1978?
YES [xx] Date 12-2014 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified 67 and days of care provided 1,752

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 Robinson # 0053421 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	171,057	24,007	2,744	197,808		197,808	3,269	201,077			1
2	Food Purchase		144,967		144,967		144,967	(11)	144,956			2
3	Housekeeping	85,250	17,926		103,176		103,176	4,358	107,534			3
4	Laundry	28,013	10,870		38,883		38,883	312	39,195			4
5	Heat and Other Utilities			68,923	68,923		68,923	1,038	69,961			5
6	Maintenance	49,735	69,144	68,339	187,218		187,218	12,718	199,936			6
7	Other (specify):*											7
8	**TOTAL General Services**	334,055	266,914	140,006	740,975		740,975	21,684	762,659			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,462,097	100,206	59,844	1,622,147	(4,487)	1,617,660	808	1,618,468			10
10a	Therapy		112,723	14,068	126,791	(122,280)	4,511		4,511			10a
11	Activities	46,585	4,834		51,419		51,419	3	51,422			11
12	Social Services	54,985	26	4,449	59,460		59,460	93	59,553			12
13	CNA Training	575			575		575		575			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,564,242	217,789	96,361	1,878,392	(126,767)	1,751,625	904	1,752,529			16
	C. General Administration											
17	Administrative	76,460			76,460		76,460		76,460			17
18	Directors Fees											18
19	Professional Services			254,746	254,746		254,746	(241,942)	12,804			19
20	Dues, Fees, Subscriptions & Promotions			156,803	156,803	(133,260)	23,543	(10,116)	13,427			20
21	Clerical & General Office Expenses	197,999	23,709	7,667	229,375		229,375	278,896	508,271			21
22	Employee Benefits & Payroll Taxes			300,447	300,447		300,447	28,086	328,533			22
23	Inservice Training & Education			797	797		797	811	1,608			23
24	Travel and Seminar			2,476	2,476		2,476	2,523	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			37,179	37,179		37,179	46,528	83,707			26
27	Other (specify):* Lost resident items			186,517	186,517		186,517	(186,477)	40			27
28	**TOTAL General Administration**	274,459	23,709	946,632	1,244,800	(133,260)	1,111,540	(81,691)	1,029,849			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,172,756	508,412	1,182,999	3,864,167	(260,027)	3,604,140	(59,103)	3,545,037			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heritage Health Robinson #0053421 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation							126,215	126,215			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			36,635	36,635		36,635	76,714	113,349			32
33	Real Estate Taxes							25,592	25,592			33
34	Rent-Facility & Grounds			319,740	319,740		319,740	(314,900)	4,840			34
35	Rent-Equipment & Vehicles			40,823	40,823		40,823	8,569	49,392			35
36	Other (specify):*											36
37	**TOTAL Ownership**			397,198	397,198		397,198	(77,810)	319,388			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			405,335	405,335	126,767	532,102	185,928	718,030			39
40	Barber and Beauty Shops			1,495	1,495		1,495		1,495			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					133,260	133,260		133,260			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			406,830	406,830	260,027	666,857	185,928	852,785			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,172,756	508,412	1,987,027	4,668,195		4,668,195	49,015	4,717,210			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 Robinson # 0053421 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	371			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	(2,962)			17
18	Fines and Penalties				18
19	Entertainment	(965)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(54,355)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(186,477)			24
25	Fund Raising, Advertising and Promotional	(7,798)			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)**	$ (252,186)		$	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)	301,201		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 301,201		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 49,015		37

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

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

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

Heritage Health Robinson

ID# 0053421

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		(54,355)	19	11
12		371	32	12
13		(186,477)	27	13
14		(7,798)	20	14
15		(2,962)	20	15
16		0	27	16
17		(965)	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**	(252,186)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Robinson # 0053421 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	3,269	0	0	0	0	0	0	0	0	3,269	1
2	Food Purchase	0	0	(11)	0	0	0	0	0	0	0	0	(11)	2
3	Housekeeping	0	0	4,358	0	0	0	0	0	0	0	0	4,358	3
4	Laundry	0	0	312	0	0	0	0	0	0	0	0	312	4
5	Heat and Other Utilities	0	0	1,038	0	0	0	0	0	0	0	0	1,038	5
6	Maintenance	0	0	12,718	0	0	0	0	0	0	0	0	12,718	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	21,684	0	0	0	0	0	0	0	0	21,684	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	(16,120)	16,928	0	0	0	0	0	0	0	0	808	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	3	0	0	0	0	0	0	0	0	3	11
12	Social Services	0	0	93	0	0	0	0	0	0	0	0	93	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	(16,120)	17,024	0	0	0	0	0	0	0	0	904	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	(54,355)	(198,683)	11,096	0	0	0	0	0	0	0	0	(241,942)	19
20	Fees, Subscriptions & Promotions	(10,760)	0	644	0	0	0	0	0	0	0	0	(10,116)	20
21	Clerical & General Office Expenses	0	0	278,896	0	0	0	0	0	0	0	0	278,896	21
22	Employee Benefits & Payroll Taxes	0	0	28,086	0	0	0	0	0	0	0	0	28,086	22
23	Inservice Training & Education	0	(72)	883	0	0	0	0	0	0	0	0	811	23
24	Travel and Seminar	(965)	0	3,488	0	0	0	0	0	0	0	0	2,523	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	46,528	0	0	0	0	0	0	0	0	46,528	26
27	Other (specify):*	(186,477)	0	0	0	0	0	0	0	0	0	0	(186,477)	27
28	**TOTAL General Administration**	(252,557)	(198,755)	369,621	0	0	0	0	0	0	0	0	(81,691)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(252,557)	(214,875)	408,329	0	0	0	0	0	0	0	0	(59,103)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Robinson # 0053421 **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	110,493	0	15,722	0	0	0	0	0	0	0	126,215	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	371	74,578	0	1,765	0	0	0	0	0	0	0	76,714	32
33	Real Estate Taxes	0	25,592	0	0	0	0	0	0	0	0	0	25,592	33
34	Rent-Facility & Grounds	0	(319,740)	0	4,840	0	0	0	0	0	0	0	(314,900)	34
35	Rent-Equipment & Vehicles	0	0	0	8,569	0	0	0	0	0	0	0	8,569	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	371	(109,077)	0	30,896	0	0	0	0	0	0	0	(77,810)	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	185,802	0	126	0	0	0	0	0	0	0	185,928	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	185,802	0	126	0	0	0	0	0	0	0	185,928	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(252,186)	(138,150)	408,329	31,022	0	0	0	0	0	0	0	49,015	45

Facility Name & ID Number Heritage Health Robinson # 0053421 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Adjustment for Related Organiza	$	GreenTree Pharmacy		$ (16,120)	$ (16,120)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy		(72)	(72)	2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy		185,802	185,802	3
4	V	19	Adjustment for Related Organization	198,683	Heritage Operations Group, LLC			(198,683)	4
5	V								5
6	V	34	Adjustment for Related Organization	319,740	Heritage Manor Real Estate, LLC			(319,740)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		25,592	25,592	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		73,715	73,715	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		110,493	110,493	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		863	863	10
11	V								11
12	V								12
13	V								13
14	Total			$ 518,423			$ 380,273	$ * (138,150)	14

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

Facility Name & ID Number Heritage Health Robinson # 0053421 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Heritage Operations Group		$ 3,269	$ 3,269	15
16	V	2	Food Purchase		Heritage Operations Group		(11)	(11)	16
17	V	3	Housekeeping		Heritage Operations Group		4,358	4,358	17
18	V	4	Laundry		Heritage Operations Group		312	312	18
19	V	5	Heat & Other Utilities		Heritage Operations Group		1,038	1,038	19
20	V	6	Maintenance		Heritage Operations Group		12,718	12,718	20
21	V	7	Other		Heritage Operations Group		0		21
22	V	9	Medical Director		Heritage Operations Group		0		22
23	V	10	Nursing & Medical Records		Heritage Operations Group		16,928	16,928	23
24	V	11	Activities		Heritage Operations Group		3	3	24
25	V	12	Social Service		Heritage Operations Group		93	93	25
26	V	13	Nurse Aide Training		Heritage Operations Group		0		26
27	V	14	Program Transportation		Heritage Operations Group		0		27
28	V	15	Other		Heritage Operations Group		0		28
29	V	17	Administrative		Heritage Operations Group		0		29
30	V	18	Directors Fees		Heritage Operations Group		0		30
31	V	19	Professional Services		Heritage Operations Group		11,096	11,096	31
32	V	20	Fees, Subscription, Promotions		Heritage Operations Group		644	644	32
33	V	21	Clerical & General Office Expenses		Heritage Operations Group		278,896	278,896	33
34	V	22	Employee Benefits & Payroll Taxes		Heritage Operations Group		28,086	28,086	34
35	V	23	Inservice Training & Education		Heritage Operations Group		883	883	35
36	V	24	Travel and Seminar		Heritage Operations Group		3,488	3,488	36
37	V	25	Other Admin. Staff Transportation		Heritage Operations Group		0		37
38	V	26	Insurance-Prop.Liab.Malpract		Heritage Operations Group		46,528	46,528	38
39	Total			$			$ 408,329	$ * 408,329	39

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

Facility Name & ID Number Heritage Health Robinson # 0053421 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	27		$	Heritage Operations Group		$ 0	$	15
16	V	30			Heritage Operations Group		15,722	15,722	16
17	V	31			Heritage Operations Group		0		17
18	V	32			Heritage Operations Group		1,765	1,765	18
19	V	33			Heritage Operations Group		0		19
20	V	34			Heritage Operations Group		4,840	4,840	20
21	V	35			Heritage Operations Group		8,569	8,569	21
22	V	36			Heritage Operations Group		0		22
23	V	38			Heritage Operations Group		0		23
24	V	39			Heritage Operations Group		126	126	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			$			$ 31,022	$ * 31,022	39

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

Facility Name & ID Number Heritage Health Robinson # 0053421 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Heritage Health Robinson # 0053421 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	67	$ 3,269	1
2	2	Food Purchase	Beds	2,493	25	(423)	0	67	(11)	2
3	3	Housekeeping	Beds	2,493	25	162,156	0	67	4,358	3
4	4	Laundry	Beds	2,493	25	11,591	0	67	312	4
5	5	Heat & Other Utilities	Beds	2,493	25	38,605	0	67	1,038	5
6	6	Maintenance	Beds	2,493	25	473,233	88,567	67	12,718	6
7	7	Other	Beds	2,493	25	0	0	67	0	7
8	9	Medical Director	Beds	2,493	25	0	0	67	0	8
9	10	Nursing & Medical Records	Beds	2,493	25	629,872	35,401	67	16,928	9
10	11	Activities	Beds	2,493	25	129	0	67	3	10
11	12	Social Service	Beds	2,493	25	3,478	3,478	67	93	11
12	13	Nurse Aide Training	Beds	2,493	25	0	0	67	0	12
13	14	Program Transportation	Beds	2,493	25	0	0	67	0	13
14	15	Other	Beds	2,493	25	0	0	67	0	14
15	17	Administrative	Beds	2,493	25	0	0	67	0	15
16	18	Directors Fees	Beds	2,493	25	0	0	67	0	16
17	19	Professional Services	Beds	2,493	25	412,869	0	67	11,096	17
18	20	Fees, Subscription, Promotions	Beds	2,493	25	23,945	0	67	644	18
19	21	Clerical & General Office Expens	Beds	2,493	25	10,377,428	9,978,005	67	278,896	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,493	25	1,045,059	0	67	28,086	20
21	23	Inservice Training & Education	Beds	2,493	25	32,865	0	67	883	21
22	24	Travel and Seminar	Beds	2,493	25	129,776	0	67	3,488	22
23	25	Other Admin. Staff Transportatio	Beds	2,493	25	0	0	67	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,493	25	1,731,253	0	67	46,528	24
25	TOTALS					$ 15,193,470	$ 10,226,789		$ 408,329	25

Facility Name & ID Number Heritage Health Robinson # 0053421 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Heritage Operations Group
Street Address: 115 W Jefferson Street
City / State / Zip Code: Bloomington, IL 61701
Phone Number: (309 828-4361
Fax Number: (309 829-5477

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,493	25	$	$	67	$	1
2	30	Depreciation	Beds	2,493	25	584,981		67	15,722	2
3	31	Amortization of Pre-Op & Org	Beds	2,493	25			67		3
4	32	Interest	Beds	2,493	25	65,658		67	1,765	4
5	33	Real Estate Taxes	Beds	2,493	25			67		5
6	34	Rent-Facility & Grounds	Beds	2,493	25	180,106		67	4,840	6
7	35	Rent-Equipment & Vehicles	Beds	2,493	25	318,843		67	8,569	7
8	36	Other	Beds	2,493	25			67		8
9	38	Medically Nec Transportation	Beds	2,493	25			67		9
10	39	Ancillary Service Centers	Beds	2,493	25	4,685		67	126	10
11	40	Barber and Beauty Shops	Beds	2,493	25			67		11
12	41	Coffee and Gift Shops	Beds	2,493	25			67		12
13	42	Other	Beds	2,493	25			67		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	$		$ 31,022	25

Facility Name & ID Number Heritage Health Robinson # 0053421 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	Morton Community Bank		xx	Mortgage			$	$			$ 73,715	1
2	Morton Community Bank		xx	Loan Fee Amortization							863	2
3												3
4												4
5												5
	Working Capital											
6	Busey Bank		xx	Working Capital							32,552	6
7	Morton Community Bank		xx	Working Capital							4,083	7
8												8
9	TOTAL Facility Related						$	$			$ 111,213	9
	B. Non-Facility Related*											
10	Interest Income										371	10
11												11
12	Allocated Corporate										1,765	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 2,136	14
15	TOTALS (line 9+line14)						$	$			$ 113,349	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 Robinson # 0053421 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	25,592	2
3. Under or (over) accrual (line 2 minus line 1).	$	25,592	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.	$	25,592	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2015	24,111	8
2016	23,929	9
2017	24,468	10
2018	24,228	11
2019	25,592	12

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

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Health Robinson COUNTY Crawford

FACILITY IDPH LICENSE NUMBER 0053421

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.	05427033042		$ 25,236.88	$ 25,237.00
2.	05427033041		$ 355.10	$ 355.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 25,591.98	$ 25,592.00

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 Robinson # 0053421 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,869 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			2014	$ 26,000	1
2					2
3	TOTALS			$ 26,000	3

Facility Name & ID Number Heritage Health Robinson # 0053421 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	67				$ 1,525,000	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2001 Improvements			2001	378,426						9
10	2002 Improvements			2002	284,194						10
11	2003 Improvements			2003	37,755						11
12	2004 Improvements			2004	3,250						12
13	2005 Improvements			2005	12,791						13
14	2006 Improvements			2006	14,553						14
15	2007 Improvements			2007	42,582						15
16	2008 Improvements			2008	38,675						16
17	2009 Improvements			2009	455,550						17
18	2010 Improvements			2010	10,159						18
19	2011 Improvements			2011	42,645						19
20	2012 Improvements			2012	14,802						20
21	2013 Improvements			2013	144,242						21
22	2014 Improvements			2014	61,039						22
23											23
24	Install 5 ton AC condenser			2015	6,200						24
25											25
26	No 2016 improvements			2016							26
27											27
28	Carpet installation-(2) corridors			2017	3,012						28
29											29
30	No 2018 improvements			2018							30
31											31
32											32
33											33
34	C/O Allocation					15,722		15,722			34
35	Book Depreciation					101,886		101,886			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 Robinson # 0053421 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38	Remove and replace all existing roofing with 50 GAF shingles	2019	92,067						38
39	Replace kitchen exhaust fan	2019	3,405						39
40									40
41	No 2020 Improvements	2020							41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									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	TOTAL (lines 4 thru 69)		$ 3,170,347	$ 117,608		$ 117,608	$	$	70

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

Facility Name & ID Number Heritage Health Robinson # 0053421 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	$ 895,515	$ 8,607	$ 8,607	$		$	71
72	Current Year Purchases	17,836						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 913,351	$ 8,607	$ 8,607	$		$	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)	$ 4,109,698	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 126,215	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 126,215	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 Robinson # 0053421 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: $ 40,823 Description: Televisions and office machines
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number Heritage Health Robinson # 0053421 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)		575		575
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 575	$	$ 575
10	SUM OF line 9, col. 1 and 2 (e)	$ 575			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 169,847	$		$ 169,847	1
2	Licensed Speech and Language Development Therapist		hrs			32,404			32,404	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			203,084	24		203,108	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				112,699		112,699	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					14,068			14,068	13
14	TOTAL			$		$ 419,403	$ 112,723		$ 532,126	14

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

STATE OF ILLINOIS

Facility Name & ID Number Heritage Health Robinson # 0053421 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	$ 12,142	$	1
2	Cash-Patient Deposits	4,451		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	133,103		3
4	Supply Inventory (priced at FIFO)	18,809		4
5	Short-Term Investments			5
6	Prepaid Insurance	5,186		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(2,963,229)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (2,789,538)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ (2,789,538)	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,451		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	118,926		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,062		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	7,527		36
37	Deferred Stimulus	139,505		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 278,471	$	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)**	$ 278,471	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,068,009)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (2,789,538)	$	48

***(See instructions.)**

Facility Name & ID Number Heritage Health Robinson # 0053421 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**	$ (2,656,055)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,656,055)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(411,954)	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)**	$ (411,954)	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)**	$ (3,068,009)	24 *

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

Facility Name & ID Number Heritage Health Robinson # 0053421 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	$ 3,647,454	1
2	Discounts and Allowances for all Levels	(1,017,834)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,629,620	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,056,825	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,056,825	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	372,146	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,739	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	196,405	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(123)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 570,167	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	(371)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (371)	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)**	$ 4,256,241	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	740,975	31
32	Health Care	1,878,392	32
33	General Administration	1,244,800	33
	B. Capital Expense		
34	Ownership	397,198	34
	C. Ancillary Expense		
35	Special Cost Centers	406,830	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)***	$ 4,668,195	40
41	**Income before Income Taxes (line 30 minus line 40)****	(411,954)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (411,954)	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 Robinson # 0053421 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	1,951	2,032	$ 85,736	$ 42.19	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,721	13,251	448,401	33.84	3
4	Licensed Practical Nurses	7,101	7,397	208,626	28.20	4
5	CNAs & Orderlies	34,816	36,267	603,503	16.64	5
6	CNA Trainees	58	61	575	9.43	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,395	4,578	115,831	25.30	8
9	Activity Director					9
10	Activity Assistants	3,132	3,262	46,585	14.28	10
11	Social Service Workers	3,453	3,597	54,985	15.29	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,424	13,983	171,057	12.23	15
16	Dishwashers					16
17	Maintenance Workers	3,322	3,460	49,735	14.37	17
18	Housekeepers	7,568	7,883	85,250	10.81	18
19	Laundry	2,957	3,080	28,013	9.10	19
20	Administrator	1,878	1,956	76,460	39.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,832	8,158	197,999	24.27	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)	104,608	108,965	$ 2,172,756 *	$ 19.94	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		$ 2,744	L1 C3	35
36	Medical Director		18,000	L9 C3	36
37	Medical Records Consultant		614	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,487	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		4,449	L12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 30,294		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		1,994	L10 C3	51
52	Certified Nurse Assistants/Aides		51,218	L10 C3	52
53	TOTAL (lines 50 - 52)		$ 53,212		53

Facility Name & ID Number Heritage Health Robinson # 0053421 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nicole Nichol	Administrator		$ 76,460
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,460

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	$ 200,391
Legal adj to Zero		54,355
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 254,746

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 22,824
Unemployment Compensation Insurance	4,224
FICA Taxes	166,216
Employee Health Insurance	81,691
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	25,492
Central Office Allocation	28,086
TOTAL (agree to Schedule V, line 22, col.8)	$ 328,533

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,519
Health Care Worker Background Check	
(Indicate # of checks performed)	5,654
Patient Background Checks	
PR	5,235
Dues & Subscriptions	5,307
License & Fees	265
Central Office Allocation	644
Less: Public Relations Expense	(5,235)
Non-allowable advertising	(2,962)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,427

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	1,768
	0
Seminar Expense	708
	2,523
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,999

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Health Robinson # 0053421 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 - $4,690**

(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. $ **133,260**
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. $ **368**

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

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

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

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

Account Number			Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg Line #	Adjustment Amount		
1009			PETTY CASH	12,142							
1010			CASH IN BANK								
1040			CASH IN BANK-PAYROLL								
1100			ACCOUNTS RECEIVABLE	133,103							
1110			MEDICARE RECEIVABLES								
1125			IPA INCOME RECEIVABLE								
1130			MEDICARE COST REPORT								
1132			US HHS STIMULUS SETTLEME	-139,505							
1140			UNAPPLIED CASH RECEIPTS								
1145			A/R SUSPENSE-REFUNDS								
1190			ACCRUED INTEREST REC								
1200			PREPAID INSURANCE	5,186							
1220			OTHER PREPAID EXPENSES								
1300			FOOD INVENTORY	18,809							
1310			SUPPLIES INVENTORY								
1409			LAND	0							
1450			FURNITURE & EQUIPMENT	0							
1460			ACCUM DEPR-FURN & EQUIP	0							
1475			BUILDING & IMPROVEMENTS	0							
1490			ACCUM DEPR-BUILDING	0							
1530			RESIDENT FUNDS	4,451							
1550			LOAN FEES	0							
1560			REAL ESTATE TAX ESCROW								
1575			REIMBURSABLE PURCHASES								
1850			INTRACOMPANY	-2,963,229							
2010			ACCOUNTS PAYABLE	0							
2095			BONUSES PAYABLE								
2100			ACCRUED PAYROLL	-38,286							
2110			ACCRUED VACATION PAY	-80,640							
2120			UC TAXES PAYABLE								
2125			FICA TAX PAYABLE	-8,062	-8,062						
2130			FIT PAYABLE								
2140			STATE W/H PAYABLE		0						
2145			EARNED INCOME CREDIT								
2150			UC FED CREDIT REDUCTION								
2230			PAYROLL SAVINGS								
2235			IRA W/HOLDINGS								
2240			UNITED WAY								
2245			GROUP INSURANCE PAYABLE								
2246			GROUP INSURANCE PAYABLE-CAFETERIA								
2260			WAGE GARNISHMENTS								
2280			MISC PAYROLL DEDUCTIONS								
2300			ACCRUED INTEREST PAYABL	0							
2310			SALES TAX PAYABLE								
2320			IPA PAYMENTS PAYABLE	-7,527							
2350			REAL ESTATE TAX PAYABLE	0							
2385			ACTIVITY FUND	0							
2390			SECURITY DEPOSITS	0							
2391			VOLUNTEER FUND								
2393			HEART FUND/BAZAAR								
2395			DEFERRED INC EMP & MEM								
2400			CURRENT PORTION LT DEBT								
2460			INCOME TAXES PAYABLE								
2512			DUE TO RESIDENTS	-4,451							
2600			MORTGAGE PAYABLE	0							
2650			EQUIPMENT LOAN PAYABLE								
2695			CURRENT PORTION LT DEBT								
2696			DEFERRED INCOME TAXES								
2710			COMMON STOCK								
2720			RETAINED EARNINGS	2,656,055							
2970			PROFIT/LOSS FOR PERIOD	411,954							
3007.1			PATIENT DAYS-PRIVATE	6,121							
3007.2			PATIENT DAYS-IPA	9,694							
3007.3			PATIENT DAYS-MEDICARE	1,752							
3007.4			PATIENT DAYS-CONVERSION								
3007.5			PATIENT DAYS-LICENSED								
3007.6			PATIENT DAYS-TOTAL								
3010		1	BASIC CHARGE-PRIVATE & VA	-3,633,689		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	-10,570		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	-196,405		0	0	0	0		
3101		17	DRUGS-OTHER								
3110		6	PT-PRIVATE	-1,056,825		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	96,477							
3140		19	LABORATORY INCOME			0	0	0	0		
3150		6	SPEECH/OT-PRIVATE			0	0	0	0		
3151		6	SPEECH/OT-IPA			0	0	0	0		
3152		6	SPEECH/OT-MED PART A			0	0	0	0		
3153		6	SPEECH/OT MED PART B								
3410		2	IPA DISCOUNTS	1,017,834		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	-372,146		42	3	0	0		
3520		16	RENT INCOME	0		6	0	6	0		
3530		13	BEAUTY SHOP	-1,739		0	0	0	0		
3560		12	ACTIVITY FUND INCOME	0		0	0	0	0		
3570		12	VENDING INCOME/EXPENSE	0		0	0	0	0		
3580		12	MANAGEMENT FEES			0	0	0	0		
3590		1	EQUIPMENT RENTAL	-3,195		0	0	0	0		
3595		21	RESIDENT TRANSPORTATION	0		0	0	0	0		
3600		21	MISC INCOME	123		0	0	0	0		
4110			GENERAL & ADMINIST WAGES	183,389	197,999	21	1	17	0		
4111			ADMINISTRATOR WAGES	76,460	76,460	17	1	0	0		
4115			VACATION & SICK - G&A	14,610		21	1	0	0		
4120	4475		EMPLOYEE BENEFITS	31,637	300,447	22	3	0	0		
4125			EMPLOYEE HEPETITIS VACCIN	0		22	3	0	0		
4130			EMPLOYEE SCHOLARSHIP WA	0	96,477	21	1	0	0		
4135			EMPLOYEE SCHOLARSHIP CC	-6,145		23	3	0	0		
4220			DIRECTORS FEES	0	0	18	3	0	0		
4250	4255		OFFICE SUPPLIES	23,709	23,709	21	2	0	0		
4260			TELEPHONE	7,667	7,667	21	3	0	0		
4275			TRAINING & EMPLOYEE DEVL	797	797	23	3	16	0	**	
4280			GENERAL TRAVEL	1,768	2,476	24	3	16	0		
4281			MEAL EXPENSE FOR TRAVEL	0		24	3	19	0		
4285			EDUCATION & SEMINAR	708		24	3	19	-965	***	
4290			HELP WANTED ADVERTISING	4,519	60,326	20	3	0	0		-36,783
4291			PROMOTIONAL ADVERTISING	2,563		20	3	25	-2,563		
4292			PUBLIC RELATIONS	5,235		20	3	25	-5,235		
4300			LICENSES & FEES	37,048		20	3	17	0		
4310			DUES & SUBSCRIPTIONS	5,307		20	3	17	-2,962		
4320			CONTRIBUTIONS	0		27	3	20	0		
4350			PROFESSIONAL FEES	56,063	254,746	19	3	22	-54,355		
4355			MEDICAL DIRECTOR	18,000	18,000	9	3	0	0		
4360			UTILIZATION REVIEW	0		10	3	0	0		
4361			OTHER PHYSICIAN FEES			39	3	0	0		
4362			MEDICAL RECORDS CONSULT	614		10	3	0	0		
4363			PHARMACIST FEES	4,487		10	3	0	0		
4364			SOC SERV/ACT CONSULT	4,449	4,449	12	3	0	0		
4370			TV RENTAL	13,439		35	3	5	0		
4380			INCOME TAXES		186,517	27	3	26	0		
4383			BACKGROUND CHECKS	5,654		20	3	26	0		
4400			PAYROLL TAXES	170,440		22	3	0	0		
4401			PAYROLL TAXES ADMINIST	0		22	3	0	0		
4410			GROUP INSURANCE	81,691		22	3	0	0		
4420			LIABILITY INSURANCE	37,179	37,179	26	3	0	0		
4425			INSURANCE-OWNERS			22	3	21	0		
4430			WORKMENS COMP INSURANC	22,824		22	3	0	0		
4450			CENTRAL OFFICE FEES	198,683		19	3	34	0	**	
4460			BAD DEBTS	186,477		27	3	24	-186,477		
4470			LOST ITEMS-RESIDENTS	40		27	3	0			
4490			MISCELLANEOUS	0		27	3	0	0		
4510			REAL ESTATE TAXES	0	0	33	3	0	0		
4600			LEASED EQUIPMENT	27,384	40,823	35	3	16	0		
5110			MAINTENANCE SALARIES	47,857	49,735	6	1	0	0		
5120			MAINTENANCE SICK & VAC	1,878		6	1	0	0		
5130			ELECTRIC	41,527	68,923	5	3	0	0		
5131			NATURAL GAS	6,349		5	3	0	0		
5132			HEATING & DEISEL OIL			5	3	0	0		
5133			WATER & SEWER	21,047		5	3	0	0		
5134			TRASH COLLECTION	12,304	68,339	6	3	0	0		
5140			PROPERTY PLANT REPLACEM	10,970	69,144	6	2	0	0		
5160			GENERAL REPAIR & MAINT	58,174		6	2	0	0		
5165			MAINTENANCE CONTRACTS	56,035		6	3	0	0		
5210			DIETARY WAGES	160,383	171,057	1	1	0	0		
5220			DIETARY SICK & VAC	10,674		1	1	0	0		
5240			DIETARY CONSULTANT	2,744	2,744	2	3	13	0		
5248			FOOD PURCHASES	145,335	144,967	2	2	0	0		
5250			SUPPLIES-DISHWASHING	5,834	24,007	1	2	0	0		
5260			DIETARY REPLACEMENT	3,267		1	2	0	0		
5270			KITCHEN SUPPLIES-PAPER	14,906		1	2	0	0		
5295			MEAL CREDIT	-368		2	2	0	0		
5310			LAUNDRY WAGES	26,628	28,013	4	1	0	0		
5340			LAUNDRY SICK & VAC	1,385		4	1	0	0		
5370			LAUNDRY REPLACEMENT	6,419	10,870	4	2	0	0		
5380			LAUNDRY REIMBURSEMENT			4	3	0	0		
5390			LAUNDRY SUPPLIES	4,451		4	2	0	0		
5410			HOUSEKEEPING WAGES	81,111	85,250	3	1	0	0		
5440			HOUSEKEEPING SICK & VAC	4,139		3	1	0	0		
5480			HOUSEKEEPING SUPPLIES	17,926	17,926	3	2	0	0		
5490			HOUSEKEEPING SUPPLIES-PF	0		3	2	0	0		
6010			RN WAGES-MEDICARE		1,462,097	10	1	0	0		
6020			RN WAGES-NON MEDICARE	412,999		10	1	0	0		
6030			DON WAGES	85,736		10	1	0	0		
6035			ADON	0		10	1	0	0		
6040			RN SICK & VACATION	35,402		10	1	0	0		
6110			LPN WAGES-MEDICARE	199,982		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	8,644		10	1	0	0		
6210			AIDE WAGES-MEDICARE			10	1	0	0		
6220			AIDE WAGES-NON MEDICARE	573,356		10	1	0	0		
6230			WARD CLERKS			10	1	0	0		
6240			AIDE VACATION & SICK	30,147		10	1	0	0		
6245			CONTRACT NURSES-RN	0		10	3	0	0		
6246			CONTRACT NURSES-LPN	1,994		10	3	0	0		
6247			CONTRACT NURSES-AIDES	51,218		10	3	0	0		
6250			NURSE AIDE TRAINING WAGES	575	575	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	107,424		10	1	0	0		
6275			REHAB SICK & VAC	8,407		10	1	0	0		
6280			NURSING DEPT EDUCATION			23	3	0	0		
6290			NURSING SUPPLIES	21,723	100,206	10	2	0	0		
6295			NURSING SUPPLIES	77,162		10	2	0	0		
6390			REPLACEMENT-NURSING	1,321		10	2	0	0		
6490			NURSING OTHER	1,531	59,844	10	3	0	0		
7280			DRUG PURCHASES	106,778	112,723	39	2	0	0	***	
7281			DRUG PURCHASES-OTHER	5,921		39	2				
7380			LABORATORY SERVICES	14,068	14,068	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	45,238	46,585	11	1	0	0		
7540			ACTIVITIES SICK & VAC	1,347		11	1	0	0		
7590			ACTIVITIES SUPPLIES	4,834	4,834	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	203,084	405,335	39	3	0	0	***	
7660			PT SUPPLIES	24		39	2	0	0		
7710			SOCIAL SERVICE WAGES	45,927	54,985	12	1	0	0		
7720			SOCIAL SERVICE SICK & VAC	9,058		12	1	0	0		
7730			SOCIAL SERVICE EXPENSES	26	26	12	2	0	0		
7740			OT FEE	169,847		39	3	0	0	***	
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0		
7770			SPEECH THERAPY FEE	32,404		39	3	0	0	***	
7800			BEAUTICIAN WAGES		0	40	1	0	0		
7810			BEAUTICIAN SICK & VAC			40	1	0	0		
7820			BEAUTICIAN FEES	1,495	1,495	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	319,740	319,740	34	3	0	0		
8120			INTEREST EXPENSE	36,635	36,635	32	3	14	371		
8130			DEPRECIATION	0	0	30	3	9	0		
8150			LOAN FEE AMORTIZATION	0		32	3	0	0		
9510			INTEREST INCOME	371		32	0	10	0		
9520			MISC NON-OPERATING INCOM	0		0	0	0	0		
9700			INCOME TAXES	0		0	0	0	0		
				4,572,089	4,668,195						
					96,106						
GRAND TOTALS				411,954					-252,186		
				(NET INCOME)							
				0							

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 162

BALANCE SHEET TOTAL 0

1,009	1,009 CASH	12,142
1,100	1,100 ACCTS RE	541,542
1,101	1,101 ALLOW. F	(408,439)
1,110	1,110 ACCTS RECEIV-M/C	
1,125	1,125 ACCTS RECEIV-IPA	
1,132	1,132 US HHS S	(139,505)
1,140	1,140 UNAPPLIED CASH RECEIPTS	
1,145	1,145 A/R SUSPENSE-REFUNDS	
1,200	1,200 PREPAID	0
1,220	1,220 OTHER PI	5,186
1,300	1,300 DIETARY I	18,809
1,310	1,310 SUPPLIES INVENTORY	
1,320	1,320 LINEN INVENTORY	
1,409	1,409 LAND	0
1,450	1,450 FURNITUF	0
1,460		0
1,475	1,475 BUILDINGS	0
1,490	1,490 ACCUM DI	0
1,530	1,530 RESIDENT	4,451
1,550	1,550 LOAN FEE	0
1,551	1,551 LOAN FEES ADDED	
1,850	1,850 INTERCOI	(2,963,229)
2,010	2,010 ACCOUNT	0
2,100	2,095 BONUSES PAYABLE	
2,100	2,100 ACCRUEI	(38,286)
2,100	2,100 PR CLEARING-BENEFITS	
2,100	2,100 PR CLEARING-LABOR	
2,110	2,110 ACCRUEI	(80,640)
2,120	2,120 U.C. TAXE	0
2,125	2,125 FICA TAXE	(8,062)
2,130	2,130 FEDERAL W/H TAX PAYABLE	
2,140	2,140 STATE W/H TAX PAYABLE	
2,152	2,152 WORKERS COMP ACCRUAL	
2,225	2,225 EMPLOYEEE INSURANCE REFUND	
2,230	2,230 PAYROLL SAVINGS	
2,235	2,240 UNITED FUND	
2,240	2,246 GROUP INSURANCE - CAFETERIA	
2,246	2,250 401K W/H	
2,250		
2,260	2,260 WAGE GA	0
2,300	2,300 ACCRUEI	0
2,320	2,320 IPA PAYMI	(7,527)
2,350	2,350 REAL EST	0
2,385		0
2,400	2,400 CURRENT PORTION OF LT DEBT	
2,512	2,512 DUE TO R	(4,451)
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	2,656,055
	net income	411,954
	balance	0

3,007	3,007 PATIENT I	6,121
3,007	3,007 PATIENT I	9,694
3,007	3,007 PATIENT I	1,752
3,007		0
3,007		
3,007		
3,007		
3,010	3,010 BASIC CH	(3,633,689)
3,020	3,020 BASIC CH	0
3,030	3,030 BASIC CH	0
3,040	ASSESSM	96,477
3,050		0
3,060		0
3,061		0
3,080	3,080 NURSING	(10,570)
3,081	3,081 NURSING	0
3,082	3,082 NURSING	0
3,083	3,083 NURSING	0
3,100	3,100 DRUGS-M	(196,405)
3,101		0
3,110	3,110 PHYSICAL	(1,056,825)
3,111		0
3,112	3,112 PHYSICAL	0
3,113	3,113 PHYSICAL	0
3,140	3,140 LABORATORY INCOME	
3,150		0
3,151		
3,152	3,152 ST/OT TH	0
3,153	3,153 ST/OT TH	0
3,160	3,185 REHAB/ISOLATION/OTHER CHG	
3,410	3,410 IPA/OTHE	0
3,411	3,411 MEDICARI	0
3,420	3,420 MEDICARI	899,680
3,452	3,452 HHS STIM	(372,146)
3,520	3,520 RENT INC	0
3,530	3,530 BEAUTY S	(1,739)
3,560		0
3,570	3,570 VENDING	0
3,590	3,590 EQUIPMEI	(3,195)
3,595	3,595 RESIDENT	0
3,600	3,600 MISC INC	123
4,110	4,110 G&A WAG	183,389
4,111	4,111 ADMINISTI	76,460
4,115	4,115 G&A PTO	14,610
4,120	4,120 EMPLOYE	31,601
4,121		0
4,130	4,130 EMPLOYE	0
4,135	4,135 EMPLOYE	(6,145)
4,250	4,250 OFFICE S	6,269
4,255	4,255 POSTAGE	556
4,260	4,260 TELEPHO	7,667
4,275	4,275 TRAINING	797
4,276		0
4,280	4,280 GENERAL	1,768
4,281	4,281 MEAL EXF	0
4,285	4,285 EDUCATIC	658
4,289	4,289 MEETINGS	50
4,290	4,290 HELP WAI	4,519
4,291	4,291 PROMOTI	2,563
4,292	4,292 PUBLIC R	5,235
4,300	4,300 LICENSE	37,048
4,310	4,310 DUES & S	5,307
4,320	4,320 CONTRIBI	0
4,350	4,350 PROFESS	56,063
4,355	4,355 MEDICAL	18,000
4,362		614
4,363		4,487
4,364	4,364 SOCIAL S	4,449
4,370	4,370 TV RENTA	13,439
4,383	4,383 BACKGRC	5,654
4,390	4,390 OTHER TA	0
4,400	4,400 PAYROLL	170,440
4,401	4,401 PAYROLL	0
4,410	4,410 GROUP IN	81,691
4,420	4,420 LIABILITY I	37,179
4,430	4,430 WORKMA	20,595
4,435	4,435 W/C-FIRS	667
4,436	4,436 DRUG TES	1,562
4,450	4,450 MANAGEM	198,683
4,460	4,460 BAD DEBT	186,477
4,461	4,461 BAD DEBT	118,154
4,470	4,470 LOST ITEI	40
4,475	4,475 UNIFORM	36
4,486	4,486 SERVICE	43,421
4,490	4,490 MISC EXP	270
4,496	4,496 MISC. M.I.S	16,884
4,510	4,510 REAL EST	0
4,600	4,600 LEASED E	27,384
5,110	5,110 MAINTENA	47,857
5,120	5,120 MAINTENA	1,878
5,130	5,130 ELECTRIC	41,527
5,131	5,131 NATURAL	6,349
5,133	5,133 WATER &	21,047
5,134	5,134 TRASH CC	12,304
5,140	5,140 PROP/PLA	10,970
5,160	5,160 GENERAL	58,174
5,165	5,165 MAINTENA	12,614
5,210	5,210 DIETARY	160,383
5,220	5,220 DIETARY I	10,674
5,248	5,248 FOOD PU	145,065
5,250	5,250 SUPPLIES	5,834
5,260	5,260 REPLACE	3,267
5,270	5,270 KITCHEN	14,906
5,295	5,295 MEAL INC	(368)
5,310	5,310 LAUNDRY	26,628
5,340	5,340 LAUNDRY	1,385
5,370	5,370 REPLACE	6,419
5,230	5,230 DIETARY	2,744
5,390	5,390 LAUNDRY	4,451
5,410	5,410 HOUSEKE	81,111
5,440	5,440 HOUSEKE	4,139
5,480	5,480 SUPPLIES	17,926
5,490	5,490 SUPPLIES	0
6,020	6,020 RN WAGE	412,999
6,030	6,030 DON WAG	85,736
6,035	6,035 ADON WA	0
6,040	6,040 RN PTO &	35,402
6,120	6,120 LPN WAG	199,982
6,140	6,140 LPN PTO	8,644
6,220	6,220 AIDES WA	573,356
6,240	6,240 AIDES PTO	30,147
6,245	RN CONT	0
6,246	LPN CONT	1,994
6,247	AIDES CO	51,218
6,250		575
6,255		0
6,260		0
6,270	6,270 REHAB W	107,424
6,275	6,275 REHAB PT	8,407
6,290	6,290 NURSING	21,723
6,295	6,295 NURSING	77,162
6,390	6,390 REPLACE	1,321
6,490	6,490 OTHER	1,531
7,280	7,280 DRUG PU	106,778
7,281	7,281 DRUG PU	5,921
7,380	7,380 LABORAT	11,796
7,391	7,390 X-RAY SE	2,257
7,393		15
7,510	7,510 ACTIVITIES	45,238
7,540	7,540 ACTIVITIES	1,347
7,590	7,590 ACTIVITIES	4,834
7,620	7,620 PHYSICAL	203,084
7,660	7,660 P.T. SUPF	24
7,710	7,710 SOCIAL S	45,927
7,720	7,720 SOCIAL S	9,058
7,730	7,730 SOCIAL S	26
7,740	7,740 OCCUPAT	169,847
7,750		0
7,770	7,770 SPEECH	32,404
7,820	7,820 BEAUTICI	1,495
7,890		0
7,960		0
8,120	8,120 INTEREST	4,083
8,125		32,552
8,130	8,130 DEPRECI	0
8,150		0
9,510	9,510 INTEREST	371
9,520	9,520 MISC NON	0
9,530	4,220	0
	8,100	319,740
	9,702	0
	5,230	0
		411,954

Expenses Fixed Assets 0

Heritage Manor - Robinson
IDPH ID# 53421
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	$	112,699
Purchased Hospital Services		397
Purchased Laboratory Services		11,796
Purchased Radiology Services		1,875
Amount Reclassified to Line 39	$	126,767

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

Line Item		
Provider Participation Fee - $1.50	$	(36,783)
Provider Assesment Fee - $6.07		(96,477)
		(133,260)
Provider Participation Fee		133,260

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

Line Item		
Pharmacy Consulting Fees	$	4,487