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: 0041699

Facility Name: Heritage Health Springfield

Address: 900 North Rutledge (Number) Springfield (City) 62702 (Zip Code)

County: Sangamon

Telephone Number: (217) 789-0930 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: 1996

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 Springfield # 0041699 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	178	Skilled (SNF)	178	65,148	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	178	TOTALS	178	65,148	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	29,437	10,653	6,960	47,050	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,437	10,653	6,960	47,050	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.22%

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 1996

J. Was the facility purchased or leased after January 1, 1978?
YES [xx] Date 1996 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified 178 and days of care provided 6,960

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 Springfield # 0041699 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	459,636	46,940	9,693	516,269		516,269	8,685	524,954			1
2	Food Purchase		428,256		428,256		428,256	(30)	428,226			2
3	Housekeeping	314,380	77,222		391,602		391,602	11,578	403,180			3
4	Laundry	130,853	12,464		143,317		143,317	828	144,145			4
5	Heat and Other Utilities			176,693	176,693		176,693	2,756	179,449			5
6	Maintenance	169,155	101,598	214,931	485,684		485,684	33,789	519,473			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,074,024	666,480	401,317	2,141,821		2,141,821	57,606	2,199,427			8
	B. Health Care and Programs											
9	Medical Director			86,250	86,250		86,250		86,250			9
10	Nursing and Medical Records	4,120,613	370,937	1,032,963	5,524,513	(25,300)	5,499,213	(274)	5,498,939			10
10a	Therapy		750,085	70,746	820,831	(794,980)	25,851		25,851			10a
11	Activities	119,256	1,415		120,671		120,671	9	120,680			11
12	Social Services	129,124		3,212	132,336		132,336	248	132,584			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,368,993	1,122,437	1,193,171	6,684,601	(820,280)	5,864,321	(17)	5,864,304			16
	C. General Administration											
17	Administrative	113,026			113,026		113,026		113,026			17
18	Directors Fees											18
19	Professional Services			488,995	488,995		488,995	(427,628)	61,367			19
20	Dues, Fees, Subscriptions & Promotions			400,871	400,871	(351,582)	49,289	(21,690)	27,599			20
21	Clerical & General Office Expenses	683,565	41,841	25,216	750,622		750,622	740,948	1,491,570			21
22	Employee Benefits & Payroll Taxes			1,227,442	1,227,442		1,227,442	74,617	1,302,059			22
23	Inservice Training & Education			439	439		439	2,203	2,642			23
24	Travel and Seminar			186	186		186	4,813	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			100,941	100,941		100,941	123,611	224,552			26
27	Other (specify):* Lost resident items			316,335	316,335		316,335	(316,158)	177			27
28	**TOTAL General Administration**	796,591	41,841	2,560,425	3,398,857	(351,582)	3,047,275	180,716	3,227,991			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,239,608	1,830,758	4,154,913	12,225,279	(1,171,862)	11,053,417	238,305	11,291,722			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 Springfield #0041699 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			908,238	908,238		908,238	41,768	950,006			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			290,247	290,247		290,247	761	291,008			32
33	Real Estate Taxes			98,911	98,911		98,911		98,911			33
34	Rent-Facility & Grounds							12,860	12,860			34
35	Rent-Equipment & Vehicles			119,524	119,524		119,524	22,765	142,289			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,416,920	1,416,920		1,416,920	78,154	1,495,074			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,258,402	1,258,402	820,280	2,078,682	176,152	2,254,834			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					351,582	351,582		351,582			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			1,258,402	1,258,402	1,171,862	2,430,264	176,152	2,606,416			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,239,608	1,830,758	6,830,235	14,900,601		14,900,601	492,611	15,393,212			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 Springfield # 0041699 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	(3,927)			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	(5,808)			17
18	Fines and Penalties	(2,158)			18
19	Entertainment	(4,453)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(52,391)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(314,000)			24
25	Fund Raising, Advertising and Promotional	(17,592)			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)**	$ (400,329)		$	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)	892,940		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 892,940		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 492,611		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 Springfield

ID# 0041699

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		(52,391)	19	11
12		(3,927)	32	12
13		(314,000)	27	13
14		(17,592)	20	14
15		(5,808)	20	15
16		(2,158)	27	16
17		(4,453)	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**	(400,329)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Springfield # 0041699 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	8,685	0	0	0	0	0	0	0	0	8,685	1
2	Food Purchase	0	0	(30)	0	0	0	0	0	0	0	0	(30)	2
3	Housekeeping	0	0	11,578	0	0	0	0	0	0	0	0	11,578	3
4	Laundry	0	0	828	0	0	0	0	0	0	0	0	828	4
5	Heat and Other Utilities	0	0	2,756	0	0	0	0	0	0	0	0	2,756	5
6	Maintenance	0	0	33,789	0	0	0	0	0	0	0	0	33,789	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	57,606	0	0	0	0	0	0	0	0	57,606	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	(45,247)	44,973	0	0	0	0	0	0	0	0	(274)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	9	0	0	0	0	0	0	0	0	9	11
12	Social Services	0	0	248	0	0	0	0	0	0	0	0	248	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	(45,247)	45,230	0	0	0	0	0	0	0	0	(17)	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	(52,391)	(404,716)	29,479	0	0	0	0	0	0	0	0	(427,628)	19
20	Fees, Subscriptions & Promotions	(23,400)	0	1,710	0	0	0	0	0	0	0	0	(21,690)	20
21	Clerical & General Office Expenses	0	0	740,948	0	0	0	0	0	0	0	0	740,948	21
22	Employee Benefits & Payroll Taxes	0	0	74,617	0	0	0	0	0	0	0	0	74,617	22
23	Inservice Training & Education	0	(144)	2,347	0	0	0	0	0	0	0	0	2,203	23
24	Travel and Seminar	(4,453)	0	9,266	0	0	0	0	0	0	0	0	4,813	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	123,611	0	0	0	0	0	0	0	0	123,611	26
27	Other (specify):*	(316,158)	0	0	0	0	0	0	0	0	0	0	(316,158)	27
28	**TOTAL General Administration**	(396,402)	(404,860)	981,978	0	0	0	0	0	0	0	0	180,716	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(396,402)	(450,107)	1,084,814	0	0	0	0	0	0	0	0	238,305	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Springfield **#** 0041699 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	41,768	0	0	0	0	0	0	0	41,768	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,927)	0	0	4,688	0	0	0	0	0	0	0	761	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	12,860	0	0	0	0	0	0	0	12,860	34
35	Rent-Equipment & Vehicles	0	0	0	22,765	0	0	0	0	0	0	0	22,765	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(3,927)	0	0	82,081	0	0	0	0	0	0	0	78,154	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	175,817	0	335	0	0	0	0	0	0	0	176,152	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	175,817	0	335	0	0	0	0	0	0	0	176,152	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(400,329)	(274,290)	1,084,814	82,416	0	0	0	0	0	0	0	492,611	45

Facility Name & ID Number Heritage Health Springfield # 0041699 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
Heritage Enterprises, Inc.	50	Attached Following This Page		Heritage Operations G	Bloomington	Mgmt. Services
Memorial Health Ventures	50			Green Tree Pharmacy	Minonk	Pharmacy
				Memorial Medical Cen	Springfield	Acute Care Hospital

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		$ (45,247)	$ (45,247)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy		(144)	(144)	2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy		175,817	175,817	3
4	V	19	Adjustment for Related Organization	404,716	Heritage Operations Group, LLC			(404,716)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 404,716			$ 130,426	$ * (274,290)	14

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

Facility Name & ID Number Heritage Health Springfield # 0041699 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		$ 8,685	$ 8,685	15
16	V	2	Food Purchase		Heritage Operations Group		(30)	(30)	16
17	V	3	Housekeeping		Heritage Operations Group		11,578	11,578	17
18	V	4	Laundry		Heritage Operations Group		828	828	18
19	V	5	Heat & Other Utilities		Heritage Operations Group		2,756	2,756	19
20	V	6	Maintenance		Heritage Operations Group		33,789	33,789	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		44,973	44,973	23
24	V	11	Activities		Heritage Operations Group		9	9	24
25	V	12	Social Service		Heritage Operations Group		248	248	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		29,479	29,479	31
32	V	20	Fees, Subscription, Promotions		Heritage Operations Group		1,710	1,710	32
33	V	21	Clerical & General Office Expenses		Heritage Operations Group		740,948	740,948	33
34	V	22	Employee Benefits & Payroll Taxes		Heritage Operations Group		74,617	74,617	34
35	V	23	Inservice Training & Education		Heritage Operations Group		2,347	2,347	35
36	V	24	Travel and Seminar		Heritage Operations Group		9,266	9,266	36
37	V	25	Other Admin. Staff Transportation		Heritage Operations Group		0		37
38	V	26	Insurance-Prop.Liab.Malpract		Heritage Operations Group		123,611	123,611	38
39	Total			$			$ 1,084,814	$ * 1,084,814	39

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

Facility Name & ID Number Heritage Health Springfield # 0041699 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	Other	$	Heritage Operations Group		$ 0	$	15
16	V	30	Depreciation		Heritage Operations Group		41,768	41,768	16
17	V	31	Amortization of Pre-Op & Org		Heritage Operations Group		0		17
18	V	32	Interest		Heritage Operations Group		4,688	4,688	18
19	V	33	Real Estate Taxes		Heritage Operations Group		0		19
20	V	34	Rent-Facility & Grounds		Heritage Operations Group		12,860	12,860	20
21	V	35	Rent-Equipment & Vehicles		Heritage Operations Group		22,765	22,765	21
22	V	36	Other		Heritage Operations Group		0		22
23	V	38	Medically Nec Transportation		Heritage Operations Group		0		23
24	V	39	Ancillary Service Centers		Heritage Operations Group		335	335	24
25	V	40	Barber and Beauty Shops		Heritage Operations Group		0		25
26	V	41	Coffee and Gift Shops		Heritage Operations Group		0		26
27	V	42	Other		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			$			$ 82,416	$ * 82,416	39

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

Facility Name & ID Number Heritage Health Springfield # 0041699 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	Heritage Enterprises Inc.			50.00	0	0			$ 0		1
2	Memorial Health Ventures			50.00	0	0			0		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 Springfield # 0041699 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	178	$ 8,685	1
2	2	Food Purchase	Beds	2,493	25	(423)	0	178	(30)	2
3	3	Housekeeping	Beds	2,493	25	162,156	0	178	11,578	3
4	4	Laundry	Beds	2,493	25	11,591	0	178	828	4
5	5	Heat & Other Utilities	Beds	2,493	25	38,605	0	178	2,756	5
6	6	Maintenance	Beds	2,493	25	473,233	88,567	178	33,789	6
7	7	Other	Beds	2,493	25	0	0	178	0	7
8	9	Medical Director	Beds	2,493	25	0	0	178	0	8
9	10	Nursing & Medical Records	Beds	2,493	25	629,872	35,401	178	44,973	9
10	11	Activities	Beds	2,493	25	129	0	178	9	10
11	12	Social Service	Beds	2,493	25	3,478	3,478	178	248	11
12	13	Nurse Aide Training	Beds	2,493	25	0	0	178	0	12
13	14	Program Transportation	Beds	2,493	25	0	0	178	0	13
14	15	Other	Beds	2,493	25	0	0	178	0	14
15	17	Administrative	Beds	2,493	25	0	0	178	0	15
16	18	Directors Fees	Beds	2,493	25	0	0	178	0	16
17	19	Professional Services	Beds	2,493	25	412,869	0	178	29,479	17
18	20	Fees, Subscription, Promotions	Beds	2,493	25	23,945	0	178	1,710	18
19	21	Clerical & General Office Expens	Beds	2,493	25	10,377,428	9,978,005	178	740,948	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,493	25	1,045,059	0	178	74,617	20
21	23	Inservice Training & Education	Beds	2,493	25	32,865	0	178	2,347	21
22	24	Travel and Seminar	Beds	2,493	25	129,776	0	178	9,266	22
23	25	Other Admin. Staff Transportatio	Beds	2,493	25	0	0	178	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,493	25	1,731,253	0	178	123,611	24
25	TOTALS					$ 15,193,470	$ 10,226,789		$ 1,084,814	25

Facility Name & ID Number Heritage Health Springfield # 0041699 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	$	$	178	$	1
2	30	Depreciation	Beds	2,493	25	584,981		178	41,768	2
3	31	Amortization of Pre-Op & Org	Beds	2,493	25			178		3
4	32	Interest	Beds	2,493	25	65,658		178	4,688	4
5	33	Real Estate Taxes	Beds	2,493	25			178		5
6	34	Rent-Facility & Grounds	Beds	2,493	25	180,106		178	12,860	6
7	35	Rent-Equipment & Vehicles	Beds	2,493	25	318,843		178	22,765	7
8	36	Other	Beds	2,493	25			178		8
9	38	Medically Nec Transportation	Beds	2,493	25			178		9
10	39	Ancillary Service Centers	Beds	2,493	25	4,685		178	335	10
11	40	Barber and Beauty Shops	Beds	2,493	25			178		11
12	41	Coffee and Gift Shops	Beds	2,493	25			178		12
13	42	Other	Beds	2,493	25			178		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	$		$ 82,416	25

Facility Name & ID Number Heritage Health Springfield # 0041699 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	Bank of Springfield		xx	Mortgage			$	$			$ 287,708	1
2	Bank of Springfield		xx	Loan Fee Amortization							2,539	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 290,247	9
	B. Non-Facility Related*											
10	Interest Income										(3,927)	10
11												11
12	Allocated Corporate										4,688	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 761	14
15	TOTALS (line 9+line14)						$	$			$ 291,008	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 Springfield # 0041699 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.**	$ 151,939	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.)		$ 127,238	2
3. Under or (over) accrual (line 2 minus line 1).		$ (24,701)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 133,600	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** $ 9,988 **For** 17 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (9,988)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 98,911	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	122,050	8
	2016	123,244	9
	2017	141,706	10
	2018	144,703	11
	2019	127,238	12

Accrual = 2019 taxes paid in 2019 * 1.05

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 Springfield COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0041699

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.	14280277027		$ 127,237.66	$ 127,238.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 127,237.66	$ 127,238.00

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 Springfield # 0041699 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 64,520 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 4

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

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

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [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			1985	$ 200,000	1
2			1996	430,000	2
3	TOTALS			$ 630,000	3

Facility Name & ID Number Heritage Health Springfield # 0041699 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	178				$ 1,900,000	$		$	$	$	4
5					1,648,258						5
6											6
7											7
8											8
	Improvement Type**										
9	1985 Improvements			1985	26,076						9
10	1986 Improvements			1986	216,545						10
11	1987 Improvements			1987	593,121						11
12	1988 Improvements			1988	29,321						12
13	1989 Improvements			1989	1,095						13
14	1990 Improvements			1990	939						14
15	1991 Improvements			1991	32,022						15
16	1992 Improvements			1992	32,593						16
17	1993 Improvements			1993	105,986						17
18	1994 Improvements			1994	59,542						18
19	1995 Improvements			1995	36,126						19
20	1996 Improvements			1996	26,011						20
21	1997 Improvements			1997	104,210						21
22	1998 Improvements			1998	11,420						22
23	1999 Improvements			1999	13,575						23
24	2000 Improvements			2000	4,941						24
25	2001 Improvements			2001	827,192						25
26	2002 Improvements			2002	214,188						26
27	2003 Improvements			2003	22,841						27
28	2004 Improvements			2004	119,806						28
29	2005 Improvements			2005	24,396						29
30	2006 Improvements			2006	274,466						30
31	2007 Improvements			2007	72,732						31
32											32
33											33
34	C/O Allocation					41,768		41,768			34
35	Book Depreciation					749,504		749,504			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 Springfield # 0041699 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	2008 Improvements	2008	1,597						38
39	2009 Improvements	2009	77,275						39
40	2010 Improvements	2010	195,370						40
41	2011 Improvements	2011	35,852						41
42	2012 Improvements	2012	22,880						42
43	2013 Improvements	2013	42,227						43
44	2014 Improvements	2014	336,155						44
45									45
46	Replace boilers	2015	11,125						46
47	Install steel covering on kitchen hood	2015	3,494						47
48	Replace fire alarm control panel	2015	23,965						48
49									49
50	Replaced kitchen exhaust fan	2017	5,456						50
51	Replaced sump pump	2017	2,654						51
52									52
53	Facility wide modernization project consisting primarily of:	2017	8,350,161						53
54	Construction of 19 bed SNF based hospice unit								54
55	Replacement of interior finishes on Floors 2-4. This includes wall repair and painting,								55
56	new ceiling tile, improved cabinetry for nursing stations, new tile								56
57	for shower rooms and new tilets and lavatories.								57
58	Install exterior insulating finish system between window columns								58
59	Re-asphalt and stripe parking lots								59
60	Install entirely new HVAC system including new hot water boiler, cooling tower and heat pumps								60
61	Replace existing water lines and sewer waste lines								61
62	Replace entire fire alarm, nurse call and basic telephone systems								62
63	Replace (2) aging emergency generators with single unit having multiple transfer switches								63
64	Replace door alarm and elopment systems								64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 15,505,613	$ 791,272		$ 791,272	$	$	70

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

Facility Name & ID Number Heritage Health Springfield # 0041699 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		$ 15,505,613	$ 791,272		$ 791,272	$	$	1
2									2
3	Install make up air unit (coil, controls and damper)	2018	7,893						3
4	Install new RTU - Ist Floor Wing	2018	62,250						4
5	Replace control board and key pad - Trane Chiller Unit	2018	4,338						5
6									6
7	Install new water coil - air conditioning unit	2019	4,365						7
8									8
9	Install new water heater	2020	11,058						9
10	Replace elevator keypads	2020	24,600						10
11									11
12									12
13									13
14									14
15									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)		$ 15,620,117	$ 791,272		$ 791,272	$	$	34

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

Facility Name & ID Number Heritage Health Springfield # 0041699 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,830,983	$ 158,734	$ 158,734	$		$	71
72	Current Year Purchases	7,602						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,838,585	$ 158,734	$ 158,734	$		$	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		2008 Ford Van	2008	$ 38,949	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$ 38,949	$	$	$		$	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)	$ 19,127,651	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 950,006	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 950,006	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 Springfield # 0041699 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: $ 109,696 Description: Oxygen cylinders, Wound VAC's, humidifiers, air mattresses, copiers and televisions
(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	Various	2019 Dodge Caravan	$ 851.00	$ 9,828	17
18					18
19					19
20					20
21	TOTAL		$ 851.00	$ 9,828	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 Springfield # 0041699 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		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	$		$ 655,291	$		$ 655,291	1
2	Licensed Speech and Language Development Therapist		hrs			124,710			124,710	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			478,401	551		478,952	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				749,534		749,534	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					70,746			70,746	13
14	TOTAL			$		$ 1,329,148	$ 750,085		$ 2,079,233	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 Springfield # 0041699 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	$ 429,742	$	1
2	Cash-Patient Deposits	65,589		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,621,611		3
4	Supply Inventory (priced at FIFO)	150,847		4
5	Short-Term Investments			5
6	Prepaid Insurance	9,834		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(255,236)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,022,387	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	857,251		13
14	Buildings, at Historical Cost	15,496,985		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,839,138		16
17	Accumulated Depreciation (book methods)	(10,031,332)		17
18	Deferred Charges	1,664,909		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): Investment in Regency RE LLC	4,775,018		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 15,601,969	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 17,624,356	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,097,957	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	65,589		28
29	Short-Term Notes Payable	320,000		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	133,600		32
33	Accrued Interest Payable	20,903		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Bed Tax	20,286		36
37	Deferred Stimulus	396,742		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,055,077	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	6,374,051		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)**	$ 6,374,051	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,429,128	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 8,195,228	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 17,624,356	$	48

*(See instructions.)

Facility Name & ID Number Heritage Health Springfield # 0041699 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**	$ 9,312,685	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 9,312,685	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,117,457)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,117,457)	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)**	$ 8,195,228	24 *

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

Facility Name & ID Number Heritage Health Springfield # 0041699 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	$ 12,401,718	1
2	Discounts and Allowances for all Levels	(4,229,450)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,172,268	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,412,341	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,412,341	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	1,016,097	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	1,228,986	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(55,198)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,189,885	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,927	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,927	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund	14	28
28a	Nurse Training Reimbursement - Prior Year	4,709	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,723	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,783,144	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,141,821	31
32	Health Care	6,684,601	32
33	General Administration	3,398,857	33
	B. Capital Expense		
34	Ownership	1,416,920	34
	C. Ancillary Expense		
35	Special Cost Centers	1,258,402	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)***	$ 14,900,601	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,117,457)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,117,457)	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 Springfield # 0041699 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	1,965	2,047	$ 92,140	$ 45.01	1
2	Assistant Director of Nursing	3,628	3,779	168,123	44.49	2
3	Registered Nurses	10,970	11,428	375,151	32.83	3
4	Licensed Practical Nurses	48,288	50,301	1,321,524	26.27	4
5	CNAs & Orderlies	113,022	117,731	2,064,385	17.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,792	4,991	99,290	19.89	8
9	Activity Director					9
10	Activity Assistants	8,757	9,122	119,256	13.07	10
11	Social Service Workers	6,481	6,751	129,124	19.13	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	35,927	37,424	459,636	12.28	15
16	Dishwashers					16
17	Maintenance Workers	8,681	9,042	169,155	18.71	17
18	Housekeepers	24,108	25,112	314,380	12.52	18
19	Laundry	9,264	9,649	130,853	13.56	19
20	Administrator	2,152	2,242	113,026	50.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	26,862	27,981	683,565	24.43	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)	304,897	317,600	$ 6,239,608 *	$ 19.65	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		$ 9,693	L1 C3	35
36	Medical Director		86,250	L9 C3	36
37	Medical Records Consultant		1,462	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		25,300	L10A C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,212	L12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 125,917		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 472,268	L10 C3	50
51	Licensed Practical Nurses		365,243	L10 C3	51
52	Certified Nurse Assistants/Aides		168,690	L10 C3	52
53	TOTAL (lines 50 - 52)		$ 1,006,201		53

Facility Name & ID Number Heritage Health Springfield # 0041699 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Maryann Walker	Administrator		$ 113,026
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 113,026

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	$ 409,506
May Cocagne & King	Audit and tax	17,600
McQuellon Consulting	Real estate tax matters	4,498
Govig Inc.	Personnel recruitment	5,000
Legal adj to Zero		52,391
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 488,995

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 66,474
Unemployment Compensation Insurance	24,840
FICA Taxes	477,330
Employee Health Insurance	365,638
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	293,160
Central Office Allocation	74,617
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,302,059

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	6,011
Health Care Worker Background Check	
(Indicate # of checks performed)	6,788
Patient Background Checks	
PR	4,729
Dues & Subscriptions	15,586
License & Fees	3,312
Central Office Allocation	1,710
Less: Public Relations Expense	(4,729)
Non-allowable advertising	(5,808)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,599

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	87
	31
Seminar Expense	68
	4,813
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,999

**See instructions.

Facility Name & ID Number Heritage Health Springfield # 0041699 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 - $10,682**

(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. $ **351,582**
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. $ **563**

(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	429,742						
1010			CASH IN BANK							
1040			CASH IN BANK-PAYROLL							
1100			ACCOUNTS RECEIVABLE	1,621,611						
1110			MEDICARE RECEIVABLES							
1125			IPA INCOME RECEIVABLE							
1130			MEDICARE COST REPORT							
1132			US HHS STIMULUS SETTLEME	0						
1140			UNAPPLIED CASH RECEIPTS							
1145			A/R SUSPENSE-REFUNDS							
1190			ACCRUED INTEREST REC							
1200			PREPAID INSURANCE	9,834						
1220			OTHER PREPAID EXPENSES							
1300			FOOD INVENTORY	150,847						
1310			SUPPLIES INVENTORY							
1409			LAND	0						
1450			FURNITURE & EQUIPMENT	2,839,138						
1460			ACCUM DEPR-FURN & EQUIP	-2,257,575						
1475			BUILDING & IMPROVEMENTS	15,496,985						
1490			ACCUM DEPR-BUILDING	-7,773,757						
1530			RESIDENT FUNDS	65,589						
1550			LOAN FEES	1,664,909						
1560			INVESTMENT IN REGENCY RE	4,775,018						
1575			GOODWILL							
1850			INTRACOMPANY	-255,236						
2010			ACCOUNTS PAYABLE	-2,097,957						
2095			BONUSES PAYABLE							
2100			ACCRUED PAYROLL	0						
2110			ACCRUED VACATION PAY	0						
2120			UC TAXES PAYABLE							
2125			FICA TAX PAYABLE	0	0					
2130			FIT PAYABLE							
2140			STATE W/H PAYABLE		0					
2145			EARNED INCOME CREDIT							
2150			UC FED CREDIT REDUCTION							
2230			PAYROLL SAVINGS							
2235			IRA W/HOLDINGS							
2240			UNITED WAY							
2245			GROUP INSURANCE PAYABLE							
2246			GROUP INSURANCE PAYABLE-CAFETERIA							
2260			WAGE GARNISHMENTS							
2280			MISC PAYROLL DEDUCTIONS							
2300			ACCRUED INTEREST PAYABLE	-20,903						
2310			SALES TAX PAYABLE							
2320			IPA PAYMENTS PAYABLE	-20,286						
2350			REAL ESTATE TAX PAYABLE	-133,600						
2385			ACTIVITY FUND	0						
2390			DEFERRED STIMULUS	-396,742						
2391			VOLUNTEER FUND							
2393			HEART FUND/BAZAAR							
2395			DEFERRED INC EMP & MEM							
2400			LINE OF CREDIT	-320,000						
2460			INCOME TAXES PAYABLE							
2512			DUE TO RESIDENTS	-65,589						
2600			MORTGAGE PAYABLE	0						
2650			EQUIPMENT LOAN PAYABLE							
2695			LONG TERM DEBT	-6,374,051						
2696			DEFERRED INCOME TAXES							
2710			COMMON STOCK							
2720			RETAINED EARNINGS	-9,312,685						
2970			PROFIT/LOSS FOR PERIOD	1,117,457						
3007.1			PATIENT DAYS-PRIVATE	10,653						
3007.2			PATIENT DAYS-IPA	29,437						
3007.3			PATIENT DAYS-MEDICARE	6,960						
3007.4			PATIENT DAYS-CONVERSION							
3007.5			PATIENT DAYS-LICENSED							
3007.6			PATIENT DAYS-TOTAL							
3010		1	BASIC CHARGE-PRIVATE & VA	-12,343,725		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	-50,617		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	-1,228,986		0	0	0	0	
3101		17	DRUGS-OTHER							
3110		6	PT-PRIVATE	-3,412,341		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	253,860						
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	4,229,450		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	-1,016,097		42	3	0	0	
3520		16	RENT INCOME	0		6	0	6	0	
3530		13	BEAUTY SHOP	0		0	0	0	0	
3560		12	ACTIVITY FUND INCOME	-14		0	0	0	0	
3570		12	VENDING INCOME/EXPENSE	0		0	0	0	0	
3580		12	NURSE AIDE TRAINING REIMB	-4,709		0	0	0	0	
3590		1	EQUIPMENT RENTAL	-7,376		0	0	0	0	
3595		21	RESIDENT TRANSPORTATION	55,233		0	0	0	0	
3600		21	MISC INCOME	-35		0	0	0	0	
4110			GENERAL & ADMINIST WAGES	616,800	683,565	21	1	17	0	
4111			ADMINISTRATOR WAGES	113,026	113,026	17	1	0	0	
4115			VACATION & SICK - G&A	66,765		21	1	0	0	
4120	4475		EMPLOYEE BENEFITS	240,347	1,227,442	22	3	0	0	
4125			EMPLOYEE HEPETITIS VACCIN	0		22	3	0	0	
4130			EMPLOYEE SCHOLARSHIP WA	35,558	253,860	21	1	0	0	
4135			EMPLOYEE SCHOLARSHIP CC	17,255		23	3	0	0	
4220			DIRECTORS FEES	0	0	18	3	0	0	
4250	4255		OFFICE SUPPLIES	41,841	41,841	21	2	0	0	
4260			TELEPHONE	25,216	25,216	21	3	0	0	
4275			TRAINING & EMPLOYEE DEVL	439	439	23	3	16	0	**
4280			GENERAL TRAVEL	87	186	24	3	16	0	
4281			MEAL EXPENSE FOR TRAVEL	31		24	3	19	0	
4285			EDUCATION & SEMINAR	68		24	3	19	-4,453	***
4290			HELP WANTED ADVERTISING	6,011	147,011	20	3	0	0	-97,722
4291			PROMOTIONAL ADVERTISING	12,863		20	3	25	-12,863	
4292			PUBLIC RELATIONS	4,729		20	3	25	-4,729	
4300			LICENSES & FEES	101,034		20	3	17	0	
4310			DUES & SUBSCRIPTIONS	15,586		20	3	17	-5,808	
4320			CONTRIBUTIONS	0		27	3	20	0	
4350			PROFESSIONAL FEES	84,279	488,995	19	3	22	-52,391	
4355			MEDICAL DIRECTOR	86,250	86,250	9	3	0	0	
4360			UTILIZATION REVIEW	0		10	3	0	0	
4361			OTHER PHYSICIAN FEES			39	3	0	0	
4362			MEDICAL RECORDS CONSULT	1,462		10	3	0	0	
4363			PHARMACIST FEES	25,300		10	3	0	0	
4364			SOC SERV/ACT CONSULT	3,212	3,212	12	3	0	0	
4370			TV RENTAL	9,240		35	3	5	0	
4380			INCOME TAXES		316,335	27	3	26	0	
4383			BACKGROUND CHECKS	6,788		20	3	26	0	
4400			PAYROLL TAXES	502,170		22	3	0	0	
4401			PAYROLL TAXES ADMINIST	0		22	3	0	0	
4410			GROUP INSURANCE	365,638		22	3	0	0	
4420			LIABILITY INSURANCE	100,941	100,941	26	3	0	0	
4425			INSURANCE-OWNERS			22	3	21	0	
4430			WORKMENS COMP INSURANC	66,474		22	3	0	0	
4450			CENTRAL OFFICE FEES	404,716		19	3	34	0	**
4460			BAD DEBTS	314,000		27	3	24	-314,000	
4470			LOST ITEMS-RESIDENTS	177		27	3	0		
4490			MISCELLANEOUS	0		27	3	0	0	
4510			REAL ESTATE TAXES	98,911	98,911	33	3	0	0	
4600			LEASED EQUIPMENT	110,284	119,524	35	3	16	0	
5110			MAINTENANCE SALARIES	155,885	169,155	6	1	0	0	
5120			MAINTENANCE SICK & VAC	13,270		6	1	0	0	
5130			ELECTRIC	103,217	176,693	5	3	0	0	
5131			NATURAL GAS	28,469		5	3	0	0	
5132			HEATING & DEISEL OIL			5	3	0	0	
5133			WATER & SEWER	45,007		5	3	0	0	
5134			TRASH COLLECTION	20,186	214,931	6	3	0	0	
5140			PROPERTY PLANT REPLACEM	12,689	101,598	6	2	0	0	
5160			GENERAL REPAIR & MAINT	88,909		6	2	0	0	
5165			MAINTENANCE CONTRACTS	194,745		6	3	0	0	
5210			DIETARY WAGES	440,503	459,636	1	1	0	0	
5220			DIETARY SICK & VAC	19,133		1	1	0	0	
5240			DIETARY CONSULTANT	9,693	9,693	2	3	13	0	
5248			FOOD PURCHASES	428,819	428,256	2	2	0	0	
5250			SUPPLIES-DISHWASHING	6,820	46,940	1	2	0	0	
5260			DIETARY REPLACEMENT	7,988		1	2	0	0	
5270			KITCHEN SUPPLIES-PAPER	32,132		1	2	0	0	
5295			MEAL CREDIT	-563		2	2	0	0	
5310			LAUNDRY WAGES	117,733	130,853	4	1	0	0	
5340			LAUNDRY SICK & VAC	13,120		4	1	0	0	
5370			LAUNDRY REPLACEMENT	4,230	12,464	4	2	0	0	
5380			LAUNDRY REIMBURSEMENT			4	3	0	0	
5390			LAUNDRY SUPPLIES	8,234		4	2	0	0	
5410			HOUSEKEEPING WAGES	298,360	314,380	3	1	0	0	
5440			HOUSEKEEPING SICK & VAC	16,020		3	1	0	0	
5480			HOUSEKEEPING SUPPLIES	86,372	77,222	3	2	0	0	
5490			HOUSEKEEPING SUPPLIES-PF	-9,150		3	2	0	0	
6010			RN WAGES-MEDICARE		4,120,613	10	1	0	0	
6020			RN WAGES-NON MEDICARE	350,465		10	1	0	0	
6030			DON WAGES	92,140		10	1	0	0	
6035			ADON	168,123		10	1	0	0	
6040			RN SICK & VACATION	24,686		10	1	0	0	
6110			LPN WAGES-MEDICARE	1,270,777		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	50,747		10	1	0	0	
6210			AIDE WAGES-MEDICARE			10	1	0	0	
6220			AIDE WAGES-NON MEDICARE	1,967,984		10	1	0	0	
6230			WARD CLERKS			10	1	0	0	
6240			AIDE VACATION & SICK	96,401		10	1	0	0	
6245			CONTRACT NURSES-RN	472,268		10	3	0	0	
6246			CONTRACT NURSES-LPN	365,243		10	3	0	0	
6247			CONTRACT NURSES-AIDES	168,690		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	
6270			REHAB WAGES	94,138		10	1	0	0	
6275			REHAB SICK & VAC	5,152		10	1	0	0	
6280			NURSING DEPT EDUCATION			23	3	0	0	
6290			NURSING SUPPLIES	42,143	370,937	10	2	0	0	
6295			NURSING SUPPLIES	325,068		10	2	0	0	
6390			REPLACEMENT-NURSING	3,726		10	2	0	0	
6490			NURSING OTHER	0	1,032,963	10	3	0	0	
7280			DRUG PURCHASES	749,534	750,085	39	2	0	0	***
7281			DRUG PURCHASES-OTHER	0		39	2			
7380			LABORATORY SERVICES	70,746	70,746	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	112,346	119,256	11	1	0	0	
7540			ACTIVITIES SICK & VAC	6,910		11	1	0	0	
7590			ACTIVITIES SUPPLIES	1,415	1,415	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	478,401	1,258,402	39	3	0	0	***
7660			PT SUPPLIES	551		39	2	0	0	
7710			SOCIAL SERVICE WAGES	124,317	129,124	12	1	0	0	
7720			SOCIAL SERVICE SICK & VAC	4,807		12	1	0	0	
7730			SOCIAL SERVICE EXPENSES	0	0	12	2	0	0	
7740			OT FEE	655,291		39	3	0	0	***
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0	
7770			SPEECH THERAPY FEE	124,710		39	3	0	0	***
7800			BEAUTICIAN WAGES		0	40	1	0	0	
7810			BEAUTICIAN SICK & VAC			40	1	0	0	
7820			BEAUTICIAN FEES	0	0	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	0	0	34	3	0	0	
8120			INTEREST EXPENSE	287,708	290,247	32	3	14	-3,927	
8130			DEPRECIATION	908,238	908,238	30	3	9	0	
8150			LOAN FEE AMORTIZATION	2,539		32	3	0	0	
9510			INTEREST INCOME	-3,927		32	0	10	0	
9520			MISC NON-OPERATING INCOM	0		0	0	0	0	
9700			INCOME TAXES	2,158		0	0	0	-2,158	
				14,642,814	14,900,601					
					257,787					
GRAND TOTALS				1,117,457					-400,329	
				(NET INCOME)						
				0						

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 162

BALANCE SHEET TOTAL -857,251

1,009	1,009 CASH	429,742
1,100	1,100 ACCTS RE	2,230,682
1,101	1,101 ALLOW. F	(609,071)
1,110	1,110 ACCTS RECEIV-M/C	
1,125	1,125 ACCTS RECEIV-IPA	
1,132	1,132 US HHS S	0
1,140	1,140 UNAPPLIED CASH RECEIPTS	
1,145	1,145 A/R SUSPENSE-REFUNDS	
1,200	1,200 PREPAID	1,838
1,220	1,220 OTHER PI	7,996
1,300	1,300 DIETARY	150,847
1,310	1,310 SUPPLIES INVENTORY	
1,320	1,320 LINEN INVENTORY	
1,409	1,409 LAND	857,251
1,450	1,450 FURNITUR	2,839,138
1,460		(2,257,575)
1,475	1,475 BUILDINGS	15,496,985
1,490	1,490 ACCUM DI	(7,773,757)
1,530	1,530 RESIDENT	65,589
1,550	1,550 LOAN FEE	26,283
1,551	1,551 GOODWIL	1,638,626
1,850	1,850 INTERCO	(255,236)
2,010	2,010 ACCOUNT	(2,097,957)
1,575	1,575 INVESTME	4,775,018
2,100	2,100 ACCRUED	0
2,100	2,100 PR CLEARING-BENEFITS	
2,100	2,100 PR CLEARING-LABOR	
2,110	2,110 ACCRUED	0
2,120	2,120 U.C. TAXE	0
2,125	2,125 FICA TAXE	0
2,130	2,130 FEDERAL W/H TAX PAYABLE	
2,140	2,140 STATE W/H TAX PAYABLE	
2,152	2,152 WORKERS COMP ACCRUAL	
2,225	2,225 EMPLOYEEE INSURANCE REFUND	
2,230	2,230 PAYROLL SAVINGS	
2,235	2,240 UNITED FUND	
2,240	2,246 GROUP INSURANCE - CAFETERIA	
2,246	2,250 401K W/H	
2,250		
2,260	2,260 WAGE GA	0
2,300	2,300 ACCRUED	(20,903)
2,320	2,320 IPA PAYME	(20,286)
2,350	2,350 REAL EST	(133,600)
2,385		(396,742)
2,400	2,400 CURRENT PORTION OF LT DEBT	
2,512	2,512 DUE TO R	(65,589)
2,600	2,600 LOC	(320,000)
2,600		0
2,625	2,625 LASALLE CONSTR. LOAN #2	
2,625		
2,695	2,695 CURRENT	(6,374,051)
2,720	2,720 RETAINED	(9,312,685)
	net income	1,117,457
	balance	0

3,007	3,007 PATIENT D	10,653
3,007	3,007 PATIENT D	29,437
3,007	3,007 PATIENT D	6,960
3,007		0
3,007		
3,007		
3,007		
3,010	3,010 BASIC CH	(12,343,725)
3,020	3,020 BASIC CH	0
3,030	3,030 BASIC CH	0
3,040	ASSESSM	253,860
3,050		0
3,060		0
3,061		0
3,080	3,080 NURSING	(50,617)
3,081	3,081 NURSING	0
3,082	3,082 NURSING	0
3,083	3,083 NURSING	0
3,100	3,100 DRUGS-M	(1,228,986)
3,101		0
3,110	3,110 PHYSICAL	(3,412,341)
3,111		0
3,112	3,112 PHYSICAL	0
3,113	3,113 PHYSICAL	0
3,140	3,140 LABORATORY INCOME	
3,150		0
3,151		
3,152	3,152 ST/OT TH	0
3,153	3,153 ST/OT TH	0
3,160	3,185 REHAB/ISOLATION/OTHER CHG	
3,410	3,410 IPA/OTHE	0
3,411	3,411 MEDICAR	0
3,420	3,420 MEDICAR	3,801,211
3,452	3,452 HHS STIM	(1,016,097)
3,520	3,520 RENT INC	0
3,530	3,530 BEAUTY S	0
3,560		(14)
3,570	3,570 VENDING	0
3,590	3,590 EQUIPME	(7,376)
3,595	3,595 RESIDEN	55,233
3,600	3,600 MISC INC	(35)
4,110	4,110 G&A WAG	616,800
4,111	4,111 ADMINIST	113,026
4,115	4,115 G&A PTO	66,765
4,120	4,120 EMPLOYE	239,252
4,121		0
4,130	4,130 EMPLOYE	35,558
4,135	4,135 EMPLOYE	17,255
4,250	4,250 OFFICE S	13,240
4,255	4,255 POSTAGE	4,329
4,260	4,260 TELEPHO	25,216
4,275	4,275 TRAINING	439
4,276		0
4,280	4,280 GENERAL	87
4,281	4,281 MEAL EXP	31
4,285	4,285 EDUCATIO	0
4,289	4,289 MEETINGS	68
4,290	4,290 HELP WAN	6,011
4,291	4,291 PROMOTI	12,863
4,292	4,292 PUBLIC R	4,729
4,300	4,300 LICENSE	101,034
4,310	4,310 DUES & S	15,586
4,320	4,320 CONTRIB	0
4,350	4,350 PROFESS	84,279
4,355	4,355 MEDICAL	86,250
4,362		1,462
4,363		25,300
4,364	4,364 SOCIAL S	3,212
4,370	4,370 TV RENTA	9,240
4,383	4,383 BACKGRO	6,788
4,390	4,390 OTHER TA	2,158
4,400	4,400 PAYROLL	502,170
4,401	4,401 PAYROLL	0
4,410	4,410 GROUP IN	365,638
4,420	4,420 LIABILITY	100,941
4,430	4,430 WORKMA	56,470
4,435	4,435 W/C-FIRS	611
4,436	4,436 DRUG TES	9,393
4,450	4,450 MANAGEM	404,716
4,460	4,460 BAD DEBT	314,000
4,461	4,461 BAD DEBT	428,239
4,470	4,470 LOST ITE	177
4,475	4,475 UNIFORM	1,095
4,486	4,486 SERVICE	138,056
4,490	4,490 MISC EXP	1,627
4,496	4,496 MISC. M.I.S	24,272
4,510	4,510 REAL EST	98,911
4,600	4,600 LEASED E	110,284
5,110	5,110 MAINTENA	155,885
5,120	5,120 MAINTENA	13,270
5,130	5,130 ELECTRIC	103,217
5,131	5,131 NATURAL	28,469
5,133	5,133 WATER &	45,007
5,134	5,134 TRASH CO	20,186
5,140	5,140 PROP/PLA	12,689
5,160	5,160 GENERAL	88,909
5,165	5,165 MAINTENA	56,689
5,210	5,210 DIETARY	440,503
5,220	5,220 DIETARY	19,133
5,248	5,248 FOOD PU	427,192
5,250	5,250 SUPPLIES	6,820
5,260	5,260 REPLACE	7,988
5,270	5,270 KITCHEN	32,132
5,295	5,295 MEAL INC	(563)
5,310	5,310 LAUNDRY	117,733
5,340	5,340 LAUNDRY	13,120
5,370	5,370 REPLACE	4,230
5,230	5,230 DIETARY	9,693
5,390	5,390 LAUNDRY	8,234
5,410	5,410 HOUSEKE	298,360
5,440	5,440 HOUSEKE	16,020
5,480	5,480 SUPPLIES	86,372
5,490	5,490 SUPPLIES	(9,150)
6,020	6,020 RN WAGE	350,465
6,030	6,030 DON WAG	92,140
6,035	6,035 ADON WA	168,123
6,040	6,040 RN PTO &	24,686
6,120	6,120 LPN WAG	1,270,777
6,140	6,140 LPN PTO	50,747
6,220	6,220 AIDES WA	1,967,984
6,240	6,240 AIDES PT	96,401
6,245	RN CONT	472,268
6,246	LPN CONT	365,243
6,247	AIDES CO	168,690
6,250		0
6,255		0
6,260		(4,709)
6,270	6,270 REHAB W	94,138
6,275	6,275 REHAB PT	5,152
6,290	6,290 NURSING	42,143
6,295	6,295 NURSING	325,068
6,390	6,390 REPLACE	3,726
6,490	6,490 OTHER	0
7,280	7,280 DRUG PU	749,534
7,281	7,281 DRUG PU	0
7,380	7,380 LABORAT	33,656
7,391	7,390 X-RAY SE	26,231
7,393		10,859
7,510	7,510 ACTIVITIE	112,346
7,540	7,540 ACTIVITIE	6,910
7,590	7,590 ACTIVITIE	1,415
7,620	7,620 PHYSICAL	478,401
7,660	7,660 P.T. SUPP	551
7,710	7,710 SOCIAL S	124,317
7,720	7,720 SOCIAL S	4,807
7,730	7,730 SOCIAL S	0
7,740	7,740 OCCUPAT	652,482
7,750		2,809
7,770	7,770 SPEECH	124,710
7,820	7,820 BEAUTICI	0
7,890		0
7,960		0
8,120	8,120 INTEREST	287,708
8,125		0
8,130	8,130 DEPRECI	908,238
8,150		2,539
9,510	9,510 INTEREST	(3,927)
9,520	9,520 MISC NON	0
9,530	4,220	0
	8,100	0
	9,702	0
	5,230	0
		1,117,457

Expenses Fixed Assets
0

Heritage Manor - Springfield
IDPH ID# 41699
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	$	749,534
Purchased Hospital Services		20,973
Purchased Laboratory Services		33,656
Purchased Radiology Services		16,117
Amount Reclassified to Line 39	$	820,280

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

Line Item		
Provider Participation Fee - $1.50	$	(97,722)
Provider Assesment Fee - $6.07		(253,860)
	$	(351,582)
Provider Participation Fee	$	351,582

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

Line Item		
Pharmacy Consulting Fees	$	25,300