		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: 0048066

Facility Name: Heritage Health Streator

Address: 1525 East Main St (Number) Streator (City) 61364 (Zip Code)

County: LaSalle

Telephone Number: (815) 672-4516 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners:

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 Streator # 0048066 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	130	Skilled (SNF)	130	47,580	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	130	TOTALS	130	47,580	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	17,242	11,292	4,048	32,582	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,242	11,292	4,048	32,582	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.48%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified 130 and days of care provided 4,048

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 Streator # 0048066 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	629,131	33,437	8,366	670,934		670,934	6,343	677,277			1
2	Food Purchase		51,911		51,911		51,911	(22)	51,889			2
3	Housekeeping	161,596	47,413		209,009		209,009	8,456	217,465			3
4	Laundry	92,311	25,332		117,643		117,643	604	118,247			4
5	Heat and Other Utilities			128,798	128,798		128,798	2,013	130,811			5
6	Maintenance	104,537	66,998	131,881	303,416		303,416	24,677	328,093			6
7	Other (specify):*											7
8	**TOTAL General Services**	987,575	225,091	269,045	1,481,711		1,481,711	42,071	1,523,782			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	3,090,313	275,944	92,225	3,458,482	(9,050)	3,449,432	762	3,450,194			10
10a	Therapy		353,563	51,146	404,709	(393,856)	10,853		10,853			10a
11	Activities	70,486	4,561		75,047		75,047	7	75,054			11
12	Social Services	52,701		3,902	56,603		56,603	181	56,784			12
13	CNA Training	7,199	6,870		14,069		14,069		14,069			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,220,699	640,938	149,673	4,011,310	(402,906)	3,608,404	950	3,609,354			16
	C. General Administration											
17	Administrative	68,593			68,593		68,593		68,593			17
18	Directors Fees											18
19	Professional Services			495,869	495,869		495,869	(468,190)	27,679			19
20	Dues, Fees, Subscriptions & Promotions			318,728	318,728	(256,839)	61,889	(40,195)	21,694			20
21	Clerical & General Office Expenses	334,113	26,950	10,290	371,353		371,353	541,141	912,494			21
22	Employee Benefits & Payroll Taxes			923,761	923,761		923,761	54,496	978,257			22
23	Inservice Training & Education			180	180		180	1,534	1,714			23
24	Travel and Seminar			4,683	4,683		4,683	316	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			75,939	75,939		75,939	90,278	166,217			26
27	Other (specify):* Lost resident items			38,504	38,504		38,504	(38,202)	302			27
28	**TOTAL General Administration**	402,706	26,950	1,867,954	2,297,610	(256,839)	2,040,771	141,178	2,181,949			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,610,980	892,979	2,286,672	7,790,631	(659,745)	7,130,886	184,199	7,315,085			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 Streator #0048066 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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							302,709	302,709			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			63,150	63,150		63,150	93,622	156,772			32
33	Real Estate Taxes							69,752	69,752			33
34	Rent-Facility & Grounds			569,400	569,400		569,400	(560,008)	9,392			34
35	Rent-Equipment & Vehicles			72,766	72,766		72,766	16,626	89,392			35
36	Other (specify):*											36
37	TOTAL Ownership			705,316	705,316		705,316	(77,299)	628,017			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,167,504	1,167,504	402,906	1,570,410	186,943	1,757,353			39
40	Barber and Beauty Shops		365	4,331	4,696		4,696		4,696			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					256,839	256,839		256,839			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		365	1,171,835	1,172,200	659,745	1,831,945	186,943	2,018,888			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,610,980	893,344	4,163,823	9,668,147		9,668,147	293,843	9,961,990			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 Streator # 0048066 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	(655)			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	(7,011)			17
18	Fines and Penalties				18
19	Entertainment	(6,451)			19
20	Contributions	(500)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(13,861)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(37,702)			24
25	Fund Raising, Advertising and Promotional	(34,433)			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)**	$ (100,613)		$	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)	394,456		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 394,456		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 293,843		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 Streator

ID# 0048066

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		(13,861)	19	11
12		(655)	32	12
13		(37,702)	27	13
14		(34,433)	20	14
15		(7,011)	20	15
16		(500)	27	16
17		(6,451)	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**	(100,613)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Streator # 0048066 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	6,343	0	0	0	0	0	0	0	0	6,343	1
2	Food Purchase	0	0	(22)	0	0	0	0	0	0	0	0	(22)	2
3	Housekeeping	0	0	8,456	0	0	0	0	0	0	0	0	8,456	3
4	Laundry	0	0	604	0	0	0	0	0	0	0	0	604	4
5	Heat and Other Utilities	0	0	2,013	0	0	0	0	0	0	0	0	2,013	5
6	Maintenance	0	0	24,677	0	0	0	0	0	0	0	0	24,677	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	42,071	0	0	0	0	0	0	0	0	42,071	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	(32,083)	32,845	0	0	0	0	0	0	0	0	762	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	7	0	0	0	0	0	0	0	0	7	11
12	Social Services	0	0	181	0	0	0	0	0	0	0	0	181	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	(32,083)	33,033	0	0	0	0	0	0	0	0	950	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	(13,861)	(475,858)	21,529	0	0	0	0	0	0	0	0	(468,190)	19
20	Fees, Subscriptions & Promotions	(41,444)	0	1,249	0	0	0	0	0	0	0	0	(40,195)	20
21	Clerical & General Office Expenses	0	0	541,141	0	0	0	0	0	0	0	0	541,141	21
22	Employee Benefits & Payroll Taxes	0	0	54,496	0	0	0	0	0	0	0	0	54,496	22
23	Inservice Training & Education	0	(180)	1,714	0	0	0	0	0	0	0	0	1,534	23
24	Travel and Seminar	(6,451)	0	6,767	0	0	0	0	0	0	0	0	316	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	90,278	0	0	0	0	0	0	0	0	90,278	26
27	Other (specify):*	(38,202)	0	0	0	0	0	0	0	0	0	0	(38,202)	27
28	**TOTAL General Administration**	(99,958)	(476,038)	717,174	0	0	0	0	0	0	0	0	141,178	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(99,958)	(508,121)	792,278	0	0	0	0	0	0	0	0	184,199	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Streator **#** 0048066 **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	272,205	0	30,504	0	0	0	0	0	0	0	302,709	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(655)	90,853	0	3,424	0	0	0	0	0	0	0	93,622	32
33	Real Estate Taxes	0	69,752	0	0	0	0	0	0	0	0	0	69,752	33
34	Rent-Facility & Grounds	0	(569,400)	0	9,392	0	0	0	0	0	0	0	(560,008)	34
35	Rent-Equipment & Vehicles	0	0	0	16,626	0	0	0	0	0	0	0	16,626	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(655)	(136,590)	0	59,946	0	0	0	0	0	0	0	(77,299)	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	186,699	0	244	0	0	0	0	0	0	0	186,943	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	186,699	0	244	0	0	0	0	0	0	0	186,943	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(100,613)	(458,012)	792,278	60,190	0	0	0	0	0	0	0	293,843	45

Facility Name & ID Number Heritage Health Streator # 0048066 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Adjustment for Related Organiza	$	GreenTree Pharmacy		$ (32,083)	$ (32,083)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy		(180)	(180)	2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy		186,699	186,699	3
4	V	19	Adjustment for Related Organization	475,858	Heritage Operations Group, LLC			(475,858)	4
5	V								5
6	V	34	Adjustment for Related Organization	569,400	Heritage Manor Real Estate, LLC			(569,400)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		69,752	69,752	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		85,710	85,710	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		272,205	272,205	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		5,143	5,143	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,045,258			$ 587,246	$ * (458,012)	14

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

Facility Name & ID Number Heritage Health Streator # 0048066 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Heritage Operations Group		$ 6,343	$ 6,343	15
16	V	2	Food Purchase		Heritage Operations Group		(22)	(22)	16
17	V	3	Housekeeping		Heritage Operations Group		8,456	8,456	17
18	V	4	Laundry		Heritage Operations Group		604	604	18
19	V	5	Heat & Other Utilities		Heritage Operations Group		2,013	2,013	19
20	V	6	Maintenance		Heritage Operations Group		24,677	24,677	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		32,845	32,845	23
24	V	11	Activities		Heritage Operations Group		7	7	24
25	V	12	Social Service		Heritage Operations Group		181	181	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		21,529	21,529	31
32	V	20	Fees, Subscription, Promotions		Heritage Operations Group		1,249	1,249	32
33	V	21	Clerical & General Office Expenses		Heritage Operations Group		541,141	541,141	33
34	V	22	Employee Benefits & Payroll Taxes		Heritage Operations Group		54,496	54,496	34
35	V	23	Inservice Training & Education		Heritage Operations Group		1,714	1,714	35
36	V	24	Travel and Seminar		Heritage Operations Group		6,767	6,767	36
37	V	25	Other Admin. Staff Transportation		Heritage Operations Group		0		37
38	V	26	Insurance-Prop.Liab.Malpract		Heritage Operations Group		90,278	90,278	38
39	Total			$			$ 792,278	$ * 792,278	39

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

Facility Name & ID Number Heritage Health Streator # 0048066 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		30,504	30,504	16
17	V	31			Heritage Operations Group		0		17
18	V	32			Heritage Operations Group		3,424	3,424	18
19	V	33			Heritage Operations Group		0		19
20	V	34			Heritage Operations Group		9,392	9,392	20
21	V	35			Heritage Operations Group		16,626	16,626	21
22	V	36			Heritage Operations Group		0		22
23	V	38			Heritage Operations Group		0		23
24	V	39			Heritage Operations Group		244	244	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			$			$ 60,190	$ * 60,190	39

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

Facility Name & ID Number Heritage Health Streator # 0048066 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	Monroe SNF Services LLC			100.00	0	0			$ 0		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Heritage Health Streator # 0048066 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	130	$ 6,343	1
2	2	Food Purchase	Beds	2,493	25	(423)	0	130	(22)	2
3	3	Housekeeping	Beds	2,493	25	162,156	0	130	8,456	3
4	4	Laundry	Beds	2,493	25	11,591	0	130	604	4
5	5	Heat & Other Utilities	Beds	2,493	25	38,605	0	130	2,013	5
6	6	Maintenance	Beds	2,493	25	473,233	88,567	130	24,677	6
7	7	Other	Beds	2,493	25	0	0	130	0	7
8	9	Medical Director	Beds	2,493	25	0	0	130	0	8
9	10	Nursing & Medical Records	Beds	2,493	25	629,872	35,401	130	32,845	9
10	11	Activities	Beds	2,493	25	129	0	130	7	10
11	12	Social Service	Beds	2,493	25	3,478	3,478	130	181	11
12	13	Nurse Aide Training	Beds	2,493	25	0	0	130	0	12
13	14	Program Transportation	Beds	2,493	25	0	0	130	0	13
14	15	Other	Beds	2,493	25	0	0	130	0	14
15	17	Administrative	Beds	2,493	25	0	0	130	0	15
16	18	Directors Fees	Beds	2,493	25	0	0	130	0	16
17	19	Professional Services	Beds	2,493	25	412,869	0	130	21,529	17
18	20	Fees, Subscription, Promotions	Beds	2,493	25	23,945	0	130	1,249	18
19	21	Clerical & General Office Expens	Beds	2,493	25	10,377,428	9,978,005	130	541,141	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,493	25	1,045,059	0	130	54,496	20
21	23	Inservice Training & Education	Beds	2,493	25	32,865	0	130	1,714	21
22	24	Travel and Seminar	Beds	2,493	25	129,776	0	130	6,767	22
23	25	Other Admin. Staff Transportatio	Beds	2,493	25	0	0	130	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,493	25	1,731,253	0	130	90,278	24
25	TOTALS					$ 15,193,470	$ 10,226,789		$ 792,278	25

Facility Name & ID Number Heritage Health Streator # 0048066 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	$	$	130	$	1
2	30	Depreciation	Beds	2,493	25	584,981		130	30,504	2
3	31	Amortization of Pre-Op & Org	Beds	2,493	25			130		3
4	32	Interest	Beds	2,493	25	65,658		130	3,424	4
5	33	Real Estate Taxes	Beds	2,493	25			130		5
6	34	Rent-Facility & Grounds	Beds	2,493	25	180,106		130	9,392	6
7	35	Rent-Equipment & Vehicles	Beds	2,493	25	318,843		130	16,626	7
8	36	Other	Beds	2,493	25			130		8
9	38	Medically Nec Transportation	Beds	2,493	25			130		9
10	39	Ancillary Service Centers	Beds	2,493	25	4,685		130	244	10
11	40	Barber and Beauty Shops	Beds	2,493	25			130		11
12	41	Coffee and Gift Shops	Beds	2,493	25			130		12
13	42	Other	Beds	2,493	25			130		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	$		$ 60,190	25

Facility Name & ID Number Heritage Health Streator # 0048066 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Busey Bank		xx	Mortgage			$	$			$ 85,710	1
2	Busey Bank		xx	Loan Fee Amortization							5,143	2
3												3
4												4
5												5
	Working Capital											
6	Busey Bank		xx	Working Capital							63,150	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 154,003	9
	B. Non-Facility Related*											
10	Interest Income										(655)	10
11												11
12	Allocated Corporate										3,424	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 2,769	14
15	TOTALS (line 9+line14)						$	$			$ 156,772	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 Streator # 0048066 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.)		$ 69,752	2
3. Under or (over) accrual (line 2 minus line 1).		$ 69,752	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.		$ 69,752	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	63,739	8
	2016	68,946	9
	2017	72,345	10
	2018	72,790	11
	2019	69,752	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 Streator COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0048066

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.	3431134000		$ 69,751.92	$ 69,752.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 69,751.92	$ 69,752.00

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 Streator # 0048066 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,770 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).

Evergreen Place-Streator - (53) unit supportive living facility - grounds are adjacent but buildings are separated.
Services are not shared.

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				$ 50,000	1
2					2
3	TOTALS			$ 50,000	3

Facility Name & ID Number Heritage Health Streator # 0048066 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	130				$ 348,848	$		$	$	$	4
5					440,122						5
6					2,594,839						6
7											7
8											8
	Improvement Type**										
9											9
10	1980 Improvements			1980	12,172						10
11	1981 Improvements			1981	13,748						11
12	1982 Improvements			1982	18,366						12
13	1983 Improvements			1983	9,250						13
14	1984 Improvements			1984	1,329						14
15	1985 Improvements			1985	4,100						15
16	1986 Improvements			1986	57,336						16
17	1988 Improvements			1988	6,225						17
18	1989 Improvements			1989	48,818						18
19	1990 Improvements			1990	22,687						19
20	1991 Improvements			1991	31,584						20
21	1992 Improvements			1992	3,560						21
22	1993 Improvements			1993	19,172						22
23	1994 Improvements			1994	23,135						23
24	1995 Improvements			1995	61,264						24
25	1996 Improvements			1996	3,910						25
26	1997 Improvements			1997	303,615						26
27	1998 Improvements			1998	14,471						27
28	1999 Improvements			1999	3,675						28
29	2000 Improvements			2000	6,510						29
30	2001 Improvements			2001	48,428						30
31	2002 Improvements			2002	70,668						31
32	2003 Improvements			2003	9,315						32
33											33
34	C/O Allocation					30,504		30,504			34
35	Book Depreciation					197,911		197,911			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 Streator # 0048066 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	2004 Improvements	2004	$ 10,481	$		$	$	$	37
38	2005 Improvements	2005	113,995						38
39	2006 Improvements	2006	85,199						39
40	2007 Improvements	2007	241,527						40
41	2008 Improvements	2008	113,324						41
42	2009 Improvements	2009	29,017						42
43	2010 Improvements	2010	20,685						43
44	2011 Improvements	2011	97,087						44
45	2012 Improvements	2012	189,872						45
46	2013 Improvements	2013	237,537						46
47	2014 Improvements	2014	353,611						47
48									48
49	Installed (2) new hot water heater expansion tanks	2015	3,785						49
50	Install electric heat in air handlers - NE and NW wings	2015	9,295						50
51	Completion of 2014 renovation to corridors 100&200 -	2015	3,650						51
52	asbestos abatement								52
53	Replace (4) wood doors	2015	3,440						53
54	Flooring replacement - Rec Room	2015	5,334						54
55	Nurse call system upgrade - telephonic and electrical upgrades	2015	33,961						55
56									56
57	No 2016 Improvements								57
58									58
59	Installed new water softener	2017	7,636						59
60	Upgraded 2015 nurse call system electronics	2017	5,088						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)		$ 5,741,671	$ 228,415		$ 228,415	$	$	70

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

Facility Name & ID Number Heritage Health Streator # 0048066 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,741,671	$ 228,415		$ 228,415	$	$	1
2									2
3	Install new condensing unit	2018	6,275						3
4									4
5	Remove and replace chimney with partial repair of roof	2019	64,262						5
6	Repair parking lot and main driveway	2019	7,080						6
7									7
8	No 2020 Improvements	2020							8
9									9
10									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)		$ 5,819,288	$ 228,415		$ 228,415	$	$	34

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

Facility Name & ID Number Heritage Health Streator # 0048066 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,700,972	$ 68,074	$ 68,074	$		$	71
72	Current Year Purchases	21,442						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,722,414	$ 68,074	$ 68,074	$		$	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		2017 Dodge Grand SW	2016	$ 43,540	$ 6,220	$ 6,220	$		$	76
77										77
78										78
79										79
80	TOTALS			$ 43,540	$ 6,220	$ 6,220	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,635,242	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 302,709	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 302,709	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 Streator # 0048066 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: $ 72,766 Description: Supplies, 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			$	$	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 Streator # 0048066 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		6,870		6,870
3	Classroom Wages (a)				
4	Clinical Wages (b)		7,199		7,199
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 14,069	$	$ 14,069
10	SUM OF line 9, col. 1 and 2 (e)	$ 14,069			

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	$		$ 542,482	$		$ 542,482	1
2	Licensed Speech and Language Development Therapist		hrs			99,471			99,471	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			525,551	1,803		527,354	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				351,760		351,760	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					51,146			51,146	13
14	TOTAL			$		$ 1,218,650	$ 353,563		$ 1,572,213	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 Streator # 0048066 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	$ 863	$	1
2	Cash-Patient Deposits	14,860		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	(84,359)		3
4	Supply Inventory (priced at FIFO)	27,346		4
5	Short-Term Investments			5
6	Prepaid Insurance	535		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	2,186,999		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,146,244	$	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)**	$ 2,146,244	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,860		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	461,485		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,300		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	13,214		36
37	Deferred Stimulus	158,586		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 650,445	$	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)**	$ 650,445	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,495,799	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,146,244	$	48

*(See instructions.)

Facility Name & ID Number Heritage Health Streator # 0048066 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**	$ 1,422,955	1
2	Restatements (describe):		2
3	Rounding	6	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,422,961	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	72,838	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)**	$ 72,838	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,495,799	24 *

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

Facility Name & ID Number Heritage Health Streator # 0048066 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	$ 8,103,694	1
2	Discounts and Allowances for all Levels	(3,040,971)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,062,723	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,516,183	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,516,183	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	672,384	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,914	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	448,211	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	35,915	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,161,424	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	655	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 655	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)**	$ 9,740,985	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,481,711	31
32	Health Care	4,011,310	32
33	General Administration	2,297,610	33
	B. Capital Expense		
34	Ownership	705,316	34
	C. Ancillary Expense		
35	Special Cost Centers	1,172,200	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)***	$ 9,668,147	40
41	**Income before Income Taxes (line 30 minus line 40)****	72,838	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 72,838	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 Streator # 0048066 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	1,940	2,020	$ 72,329	$ 35.81	1
2	Assistant Director of Nursing	1,897	1,976	68,155	34.49	2
3	Registered Nurses	26,658	27,769	953,699	34.34	3
4	Licensed Practical Nurses	14,365	14,964	457,670	30.58	4
5	CNAs & Orderlies	91,915	95,744	1,538,460	16.07	5
6	CNA Trainees	769	801	7,199	8.99	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,698	4,894	70,486	14.40	10
11	Social Service Workers	1,985	2,068	52,701	25.48	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	51,527	53,674	629,131	11.72	15
16	Dishwashers					16
17	Maintenance Workers	5,444	5,671	104,537	18.43	17
18	Housekeepers	14,155	14,745	161,596	10.96	18
19	Laundry	7,488	7,800	92,311	11.83	19
20	Administrator	1,714	1,786	68,593	38.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,645	21,505	334,113	15.54	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)	245,200	255,417	$ 4,610,980 *	$ 18.05	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 8,366	L1 C3	35
36	Medical Director		2,400	L9 C3	36
37	Medical Records Consultant		667	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		9,050	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		3,902	L12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 24,385		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 10,254	L10 C3	50
51	Licensed Practical Nurses		9,597	L10 C3	51
52	Certified Nurse Assistants/Aides		61,834	L10 C3	52
53	TOTAL (lines 50 - 52)		$ 81,685		53

Facility Name & ID Number Heritage Health Streator # 0048066 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bonnie Bradley	Administrator		$ 68,593
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 68,593

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	$ 482,008
Legal adj to Zero		13,861
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 495,869

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 61,871
Unemployment Compensation Insurance	19,263
FICA Taxes	352,740
Employee Health Insurance	327,761
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	162,126
Central Office Allocation	54,496
TOTAL (agree to Schedule V, line 22, col.8)	$ 978,257

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	6,866
Health Care Worker Background Check	
(Indicate # of checks performed)	3,392
Patient Background Checks	
PR	23,410
Dues & Subscriptions	11,560
License & Fees	5,638
Central Office Allocation	1,249
Less: Public Relations Expense	(23,410)
Non-allowable advertising	(7,011)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,694

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	2,884
	0
Seminar Expense	1,799
	316
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 Streator # 0048066 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI - $9,102**

(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. $ **256,839**
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. $ **275,522**

(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	863						
1010			CASH IN BANK							
1040			CASH IN BANK-PAYROLL							
1100			ACCOUNTS RECEIVABLE	-84,359						
1110			MEDICARE RECEIVABLES							
1125			IPA INCOME RECEIVABLE							
1130			MEDICARE COST REPORT							
1132			US HHS STIMULUS SETTLEME	-158,586						
1140			UNAPPLIED CASH RECEIPTS							
1145			A/R SUSPENSE-REFUNDS							
1190			ACCRUED INTEREST REC							
1200			PREPAID INSURANCE	535						
1220			OTHER PREPAID EXPENSES							
1300			FOOD INVENTORY	27,346						
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	14,860						
1550			LOAN FEES	0						
1560			REAL ESTATE TAX ESCROW							
1575			REIMBURSABLE PURCHASES							
1850			INTRACOMPANY	2,186,999						
2010			ACCOUNTS PAYABLE	0						
2095			BONUSES PAYABLE							
2100			ACCRUED PAYROLL	-159,821						
2110			ACCRUED VACATION PAY	-301,664						
2120			UC TAXES PAYABLE							
2125			FICA TAX PAYABLE	-2,300	-2,300					
2130			FIT PAYABLE							
2140			STATE W/H PAYABLE		0					
2145			EARNED INCOME CREDIT							
2150			UC FED CREDIT REDUCTION							
2230			PAYROLL SAVINGS							
2235			IRA W/HOLDINGS							
2240			UNITED WAY							
2245			GROUP INSURANCE PAYABLE							
2246			GROUP INSURANCE PAYABLE-CAFETERIA							
2260			WAGE GARNISHMENTS							
2280			MISC PAYROLL DEDUCTIONS							
2300			ACCRUED INTEREST PAYABLE	0						
2310			SALES TAX PAYABLE							
2320			IPA PAYMENTS PAYABLE	-13,214						
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	-14,860						
2600			MORTGAGE PAYABLE	0						
2650			EQUIPMENT LOAN PAYABLE							
2695			CURRENT PORTION LT DEBT							
2696			DEFERRED INCOME TAXES							
2710			COMMON STOCK							
2720			RETAINED EARNINGS	-1,422,961						
2970			PROFIT/LOSS FOR PERIOD	-72,838						
3007.1			PATIENT DAYS-PRIVATE	11,292						
3007.2			PATIENT DAYS-IPA	17,242						
3007.3			PATIENT DAYS-MEDICARE	4,048						
3007.4			PATIENT DAYS-CONVERSION							
3007.5			PATIENT DAYS-LICENSED							
3007.6			PATIENT DAYS-TOTAL							
3010		1	BASIC CHARGE-PRIVATE & VA	-8,066,875		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	-25,786		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	-448,211		0	0	0	0	
3101		17	DRUGS-OTHER							
3110		6	PT-PRIVATE	-3,516,183		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	185,469						
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	3,040,971		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	-672,384		42	3	0	0	
3520		16	RENT INCOME	0		6	0	6	0	
3530		13	BEAUTY SHOP	-4,914		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	-11,033		0	0	0	0	
3595		21	RESIDENT TRANSPORTATION	-35,881		0	0	0	0	
3600		21	MISC INCOME	-34		0	0	0	0	
4110			GENERAL & ADMINIST WAGES	312,713	334,113	21	1	17	0	
4111			ADMINISTRATOR WAGES	68,593	68,593	17	1	0	0	
4115			VACATION & SICK - G&A	21,400		21	1	0	0	
4120	4475		EMPLOYEE BENEFITS	153,882	923,761	22	3	0	0	
4125			EMPLOYEE HEPETITIS VACCIN	0		22	3	0	0	
4130			EMPLOYEE SCHOLARSHIP WA	10,343	185,469	21	1	0	0	
4135			EMPLOYEE SCHOLARSHIP CC	-2,099		23	3	0	0	
4220			DIRECTORS FEES	0	0	18	3	0	0	
4250	4255		OFFICE SUPPLIES	26,950	26,950	21	2	0	0	
4260			TELEPHONE	10,290	10,290	21	3	0	0	
4275			TRAINING & EMPLOYEE DEVL	180	180	23	3	16	0 **	
4280			GENERAL TRAVEL	2,884	4,683	24	3	16	0	
4281			MEAL EXPENSE FOR TRAVEL	0		24	3	19	0	
4285			EDUCATION & SEMINAR	1,799		24	3	19	-6,451 ***	
4290			HELP WANTED ADVERTISING	6,866	133,259	20	3	0	0	-71,370
4291			PROMOTIONAL ADVERTISING	11,023		20	3	25	-11,023	
4292			PUBLIC RELATIONS	23,410		20	3	25	-23,410	
4300			LICENSES & FEES	77,008		20	3	17	0	
4310			DUES & SUBSCRIPTIONS	11,560		20	3	17	-7,011	
4320			CONTRIBUTIONS	500		27	3	20	-500	
4350			PROFESSIONAL FEES	20,011	495,869	19	3	22	-13,861	
4355			MEDICAL DIRECTOR	2,400	2,400	9	3	0	0	
4360			UTILIZATION REVIEW	0		10	3	0	0	
4361			OTHER PHYSICIAN FEES			39	3	0	0	
4362			MEDICAL RECORDS CONSULT	667		10	3	0	0	
4363			PHARMACIST FEES	9,050		10	3	0	0	
4364			SOC SERV/ACT CONSULT	3,902	3,902	12	3	0	0	
4370			TV RENTAL	26,192		35	3	5	0	
4380			INCOME TAXES		38,504	27	3	26	0	
4383			BACKGROUND CHECKS	3,392		20	3	26	0	
4400			PAYROLL TAXES	372,003		22	3	0	0	
4401			PAYROLL TAXES ADMINIST	0		22	3	0	0	
4410			GROUP INSURANCE	327,761		22	3	0	0	
4420			LIABILITY INSURANCE	75,939	75,939	26	3	0	0	
4425			INSURANCE-OWNERS			22	3	21	0	
4430			WORKMENS COMP INSURANC	61,871		22	3	0	0	
4450			CENTRAL OFFICE FEES	475,858		19	3	34	0 **	
4460			BAD DEBTS	37,702		27	3	24	-37,702	
4470			LOST ITEMS-RESIDENTS	302		27	3	0		
4490			MISCELLANEOUS	0		27	3	0	0	
4510			REAL ESTATE TAXES	0	0	33	3	0	0	
4600			LEASED EQUIPMENT	46,574	72,766	35	3	16	0	
5110			MAINTENANCE SALARIES	95,813	104,537	6	1	0	0	
5120			MAINTENANCE SICK & VAC	8,724		6	1	0	0	
5130			ELECTRIC	69,995	128,798	5	3	0	0	
5131			NATURAL GAS	24,799		5	3	0	0	
5132			HEATING & DEISEL OIL			5	3	0	0	
5133			WATER & SEWER	34,004		5	3	0	0	
5134			TRASH COLLECTION	13,421	131,881	6	3	0	0	
5140			PROPERTY PLANT REPLACEM	6,448	66,998	6	2	0	0	
5160			GENERAL REPAIR & MAINT	60,550		6	2	0	0	
5165			MAINTENANCE CONTRACTS	118,460		6	3	0	0	
5210			DIETARY WAGES	591,642	629,131	1	1	0	0	
5220			DIETARY SICK & VAC	37,489		1	1	0	0	
5240			DIETARY CONSULTANT	8,366	8,366	2	3	13	0	
5248			FOOD PURCHASES	327,433	51,911	2	2	0	0	
5250			SUPPLIES-DISHWASHING	6,675	33,437	1	2	0	0	
5260			DIETARY REPLACEMENT	2,457		1	2	0	0	
5270			KITCHEN SUPPLIES-PAPER	24,305		1	2	0	0	
5295			MEAL CREDIT	-275,522		2	2	0	0	
5310			LAUNDRY WAGES	86,794	92,311	4	1	0	0	
5340			LAUNDRY SICK & VAC	5,517		4	1	0	0	
5370			LAUNDRY REPLACEMENT	19,376	25,332	4	2	0	0	
5380			LAUNDRY REIMBURSEMENT			4	3	0	0	
5390			LAUNDRY SUPPLIES	5,956		4	2	0	0	
5410			HOUSEKEEPING WAGES	151,647	161,596	3	1	0	0	
5440			HOUSEKEEPING SICK & VAC	9,949		3	1	0	0	
5480			HOUSEKEEPING SUPPLIES	47,413	47,413	3	2	0	0	
5490			HOUSEKEEPING SUPPLIES-PF	0		3	2	0	0	
6010			RN WAGES-MEDICARE		3,090,313	10	1	0	0	
6020			RN WAGES-NON MEDICARE	862,435		10	1	0	0	
6030			DON WAGES	72,329		10	1	0	0	
6035			ADON	68,155		10	1	0	0	
6040			RN SICK & VACATION	91,264		10	1	0	0	
6110			LPN WAGES-MEDICARE	411,198		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	46,472		10	1	0	0	
6210			AIDE WAGES-MEDICARE			10	1	0	0	
6220			AIDE WAGES-NON MEDICARE	1,433,639		10	1	0	0	
6230			WARD CLERKS			10	1	0	0	
6240			AIDE VACATION & SICK	104,821		10	1	0	0	
6245			CONTRACT NURSES-RN	10,254		10	3	0	0	
6246			CONTRACT NURSES-LPN	9,597		10	3	0	0	
6247			CONTRACT NURSES-AIDES	61,834		10	3	0	0	
6250			NURSE AIDE TRAINING WAGES	7,199	7,199	13	1	0	0	
6255			NURSE AID TRAINING EXP	6,870	6,870	13	2	0	0	
6260			NURSE AIDE TRAINING REIMB	0		0	0	0	0	
6270			REHAB WAGES	0		10	1	0	0	
6275			REHAB SICK & VAC	0		10	1	0	0	
6280			NURSING DEPT EDUCATION			23	3	0	0	
6290			NURSING SUPPLIES	47,377	275,944	10	2	0	0	
6295			NURSING SUPPLIES	224,961		10	2	0	0	
6390			REPLACEMENT-NURSING	3,606		10	2	0	0	
6490			NURSING OTHER	823	92,225	10	3	0	0	
7280			DRUG PURCHASES	340,937	353,563	39	2	0	0 ***	
7281			DRUG PURCHASES-OTHER	10,823		39	2			
7380			LABORATORY SERVICES	51,146	51,146	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	63,958	70,486	11	1	0	0	
7540			ACTIVITIES SICK & VAC	6,528		11	1	0	0	
7590			ACTIVITIES SUPPLIES	4,561	4,561	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	525,551	1,167,504	39	3	0	0 ***	
7660			PT SUPPLIES	1,803		39	2	0	0	
7710			SOCIAL SERVICE WAGES	47,599	52,701	12	1	0	0	
7720			SOCIAL SERVICE SICK & VAC	5,102		12	1	0	0	
7730			SOCIAL SERVICE EXPENSES	0	0	12	2	0	0	
7740			OT FEE	542,482		39	3	0	0 ***	
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0	
7770			SPEECH THERAPY FEE	99,471		39	3	0	0 ***	
7800			BEAUTICIAN WAGES		0	40	1	0	0	
7810			BEAUTICIAN SICK & VAC			40	1	0	0	
7820			BEAUTICIAN FEES	4,331	4,331	40	3	0	0	
7890			BEAUTY SHOP SUPPLIES	365	365	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	569,400	569,400	34	3	0	0	
8120			INTEREST EXPENSE	63,150	63,150	32	3	14	-655	
8130			DEPRECIATION	0	0	30	3	9	0	
8150			LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510			INTEREST INCOME	-655		32	0	10	0	
9520			MISC NON-OPERATING INCOM	0		0	0	0	0	
9700			INCOME TAXES	0		0	0	0	0	
				9,482,023	9,668,147					
					186,124					
GRAND TOTALS				-72,838					-100,613	
				(NET INCOME)						
				0						
			FACILITY NAME:							
			FACILITY ID:	0						
			FACILITY UNITS:	162						
			BALANCE SHEET TOTAL	0						

1,009	1,009 CASH	863
1,100	1,100 ACCTS RE	78,443
1,101	1,101 ALLOW. F	(162,802)
1,110	1,110 ACCTS RECEIV-M/C	
1,125	1,125 ACCTS RECEIV-IPA	
1,132	1,132 US HHS S	(158,586)
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	535
1,300	1,300 DIETARY I	27,346
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 BUILDING!	0
1,490	1,490 ACCUM DI	0
1,530	1,530 RESIDENT	14,860
1,550	1,550 LOAN FEE	0
1,551	1,551 LOAN FEES ADDED	
1,850	1,850 INTERCOI	2,186,999
2,010	2,010 ACCOUNT	0
2,100	2,095 BONUSES PAYABLE	
2,100	2,100 ACCRUEI	(159,821)
2,100	2,100 PR CLEARING-BENEFITS	
2,100	2,100 PR CLEARING-LABOR	
2,110	2,110 ACCRUEI	(301,664)
2,120	2,120 U.C. TAXE	0
2,125	2,125 FICA TAXE	(2,300)
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	(13,214)
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	(14,860)
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	(1,422,961)
	net income	(72,838)
	balance	0

3,007	3,007 PATIENT I	11,292
3,007	3,007 PATIENT I	17,242
3,007	3,007 PATIENT I	4,048
3,007		0
3,007		
3,007		
3,007		
3,010	3,010 BASIC CH	(8,066,875)
3,020	3,020 BASIC CH	0
3,030	3,030 BASIC CH	0
3,040	ASSESSM	185,469
3,050		0
3,060		0
3,061		0
3,080	3,080 NURSING	(25,786)
3,081	3,081 NURSING	0
3,082	3,082 NURSING	0
3,083	3,083 NURSING	0
3,100	3,100 DRUGS-M	(448,211)
3,101		0
3,110	3,110 PHYSICAL	(3,516,183)
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	2,937,504
3,452	3,452 HHS STIM	(672,384)
3,520	3,520 RENT INC	0
3,530	3,530 BEAUTY S	(4,914)
3,560		0
3,570	3,570 VENDING	0
3,590	3,590 EQUIPMEI	(11,033)
3,595	3,595 RESIDENT	(35,881)
3,600	3,600 MISC INC(	(34)
4,110	4,110 G&A WAG	312,713
4,111	4,111 ADMINISTI	68,593
4,115	4,115 G&A PTO	21,400
4,120	4,120 EMPLOYE	152,858
4,121		0
4,130	4,130 EMPLOYE	10,343
4,135	4,135 EMPLOYE	(2,099)
4,250	4,250 OFFICE S	10,335
4,255	4,255 POSTAGE	5,744
4,260	4,260 TELEPHO	10,290
4,275	4,275 TRAINING	180
4,276		0
4,280	4,280 GENERAL	2,884
4,281	4,281 MEAL EXF	0
4,285	4,285 EDUCATI(	1,799
4,289	4,289 MEETING!	0
4,290	4,290 HELP WAI	6,866
4,291	4,291 PROMOTI	11,023
4,292	4,292 PUBLIC R	23,410
4,300	4,300 LICENSE	77,008
4,310	4,310 DUES & S	11,560
4,320	4,320 CONTRIBI	500
4,350	4,350 PROFESS	20,011
4,355	4,355 MEDICAL	2,400
4,362		667
4,363		9,050
4,364	4,364 SOCIAL S	3,902
4,370	4,370 TV RENTA	26,192
4,383	4,383 BACKGRO	3,392
4,390	4,390 OTHER TA	0
4,400	4,400 PAYROLL	372,003
4,401	4,401 PAYROLL	0
4,410	4,410 GROUP IN	327,761
4,420	4,420 LIABILITY I	75,939
4,430	4,430 WORKMA	59,105
4,435	4,435 W/C-FIRS	0
4,436	4,436 DRUG TE	2,766
4,450	4,450 MANAGEN	475,858
4,460	4,460 BAD DEBT	37,702
4,461	4,461 BAD DEBT	103,467
4,470	4,470 LOST ITEI	302
4,475	4,475 UNIFORM	1,024
4,486	4,486 SERVICE	107,889
4,490	4,490 MISC EXP	438
4,496	4,496 MISC. M.I.S	10,871
4,510	4,510 REAL EST	0
4,600	4,600 LEASED E	46,574
5,110	5,110 MAINTENA	95,813
5,120	5,120 MAINTENA	8,724
5,130	5,130 ELECTRIC	69,995
5,131	5,131 NATURAL	24,799
5,133	5,133 WATER &	34,004
5,134	5,134 TRASH C(	13,421
5,140	5,140 PROP/PL/	6,448
5,160	5,160 GENERAL	60,550
5,165	5,165 MAINTENA	10,571
5,210	5,210 DIETARY	591,642
5,220	5,220 DIETARY	37,489
5,248	5,248 FOOD PU	326,995
5,250	5,250 SUPPLIES	6,675
5,260	5,260 REPLACE	2,457
5,270	5,270 KITCHEN	24,305
5,295	5,295 MEAL INC(	(275,522)
5,310	5,310 LAUNDRY	86,794
5,340	5,340 LAUNDRY	5,517
5,370	5,370 REPLACE	19,376
5,230	5,230 DIETARY	8,366
5,390	5,390 LAUNDRY	5,956
5,410	5,410 HOUSEKE	151,647
5,440	5,440 HOUSEKE	9,949
5,480	5,480 SUPPLIES	47,413
5,490	5,490 SUPPLIES	0
6,020	6,020 RN WAGE	862,435
6,030	6,030 DON WAG	72,329
6,035	6,035 ADON WA	68,155
6,040	6,040 RN PTO &	91,264
6,120	6,120 LPN WAG	411,198
6,140	6,140 LPN PTO	46,472
6,220	6,220 AIDES WA	1,433,639
6,240	6,240 AIDES PT	104,821
6,245	RN CONT	10,254
6,246	LPN CONT	9,597
6,247	AIDES CO	61,834
6,250		7,199
6,255		6,870
6,260		0
6,270	6,270 REHAB W	0
6,275	6,275 REHAB PT	0
6,290	6,290 NURSING	47,377
6,295	6,295 NURSING	224,961
6,390	6,390 REPLACE	3,606
6,490	6,490 OTHER	823
7,280	7,280 DRUG PU	340,937
7,281	7,281 DRUG PU	10,823
7,380	7,380 LABORAT	31,902
7,391	7,390 X-RAY SE	19,330
7,393		(86)
7,510	7,510 ACTIVITIE	63,958
7,540	7,540 ACTIVITIE	6,528
7,590	7,590 ACTIVITIE	4,561
7,620	7,620 PHYSICAL	525,551
7,660	7,660 P.T. SUPF	1,803
7,710	7,710 SOCIAL S	47,599
7,720	7,720 SOCIAL S	5,102
7,730	7,730 SOCIAL S	0
7,740	7,740 OCCUPAT	542,482
7,750		
7,770	7,770 SPEECH	99,471
7,820	7,820 BEAUTICI	4,331
7,890		365
7,960		0
8,120	8,120 INTEREST	0
8,125		63,150
8,130	8,130 DEPRECI	0
8,150		0
9,510	9,510 INTEREST	(655)
9,520	9,520 MISC NON	0
9,530	4,220	0
	8,100	569,400
	9,702	0
	5,230	0
		(72,838)

Expenses Fixed Assets

0

HFS 3745 (N-4-99)

IL478-2471

Heritage Manor - Streator
IDPH ID# 48066
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	$	351,760
Purchased Hospital Services		10,749
Purchased Laboratory Services		31,902
Purchased Radiology Services		8,495
Amount Reclassified to Line 39	$	402,906

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

Line Item		
Provider Participation Fee - $1.50	$	(71,370)
Provider Assesment Fee - $6.07		(185,469)
	$	(256,839)
Provider Participation Fee	$	256,839

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

Line Item		
Pharmacy Consultant Expense	$	9,050