

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0048900</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Heritage Health Litchfield</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>628 S Illinois St</u> <u>Litchfield</u> <u>62056</u>																									
Number City Zip Code																									
County: <u>Montgomery</u>																									
Telephone Number: <u>(217) 324-2153</u> Fax # ()																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>David M Underwood</u></td></tr><tr><td>(Title) <u>EVP & CFO</u></td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) () Fax # ()</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>David M Underwood</u>	(Title) <u>EVP & CFO</u>	(Date) _____	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) () Fax # ()											
Officer or Administrator of Provider	(Signed) _____																								
	(Type or Print Name) <u>David M Underwood</u>																								
	(Title) <u>EVP & CFO</u>																								
	(Date) _____																								
Paid Preparer	(Signed) _____																								
	(Date) _____																								
	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
	(Telephone) () Fax # ()																								
Date of Initial License for Current Owners: <u>July 2007</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
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	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		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																							
Name: <u>David M Underwood</u> Telephone Number: <u>(309)8237135</u> Email Address: _____																									

Facility Name & ID Number Heritage Health Litchfield

0048900 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>92</u>	Skilled (SNF)	<u>92</u>	<u>33,672</u>	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	<u>92</u>	TOTALS	<u>92</u>	<u>33,672</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>13,772</u>	<u>5,709</u>	<u>2,625</u>	<u>22,106</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,772</u>	<u>5,709</u>	<u>2,625</u>	<u>22,106</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.65%

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

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started July 2007

J. Was the facility purchased or leased after January 1, 1978? YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 92 and days of care provided 2,625

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: _____ Fiscal Year: _____
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Heritage Health Litchfield # 0048900 Report Period Beginning: 1/1/2020 Ending: 12/31/2020
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	203,163	13,991	6,126	223,280		223,280	4,489	227,769			1
2	Food Purchase		179,314		179,314		179,314	(16)	179,298			2
3	Housekeeping	109,124	29,531		138,655		138,655	5,984	144,639			3
4	Laundry	40,551	17,846		58,397		58,397	428	58,825			4
5	Heat and Other Utilities			82,865	82,865		82,865	1,425	84,290			5
6	Maintenance	71,428	27,962	91,039	190,429		190,429	17,464	207,893			6
7	Other (specify):*											7
8	TOTAL General Services	424,266	268,644	180,030	872,940		872,940	29,774	902,714			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	1,777,336	120,968	6,023	1,904,327	(4,767)	1,899,560	7,445	1,907,005			10
10a	Therapy		137,683	20,152	157,835	(152,922)	4,913		4,913			10a
11	Activities	44,110	854		44,964		44,964	5	44,969			11
12	Social Services	46,400		1,927	48,327		48,327	128	48,455			12
13	CNA Training	1,342			1,342		1,342		1,342			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,869,188	259,505	52,102	2,180,795	(157,689)	2,023,106	7,578	2,030,684			16
	C. General Administration											
17	Administrative	86,416			86,416		86,416		86,416			17
18	Directors Fees											18
19	Professional Services			256,175	256,175		256,175	(237,886)	18,289			19
20	Dues, Fees, Subscriptions & Promotions			197,960	197,960	(174,949)	23,011	(8,674)	14,337			20
21	Clerical & General Office Expenses	152,047	17,631	10,005	179,683		179,683	382,962	562,645			21
22	Employee Benefits & Payroll Taxes			425,568	425,568		425,568	38,566	464,134			22
23	Inservice Training & Education			91	91		91	1,141	1,232			23
24	Travel and Seminar			1,520	1,520		1,520	3,479	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			53,589	53,589		53,589	63,889	117,478			26
27	Other (specify):*			77,283	77,283		77,283	(77,283)				27
28	TOTAL General Administration	238,463	17,631	1,022,191	1,278,285	(174,949)	1,103,336	166,194	1,269,530			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,531,917	545,780	1,254,323	4,332,020	(332,638)	3,999,382	203,546	4,202,928			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							198,816	198,816			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,699	44,699		44,699	74,718	119,417			32
33	Real Estate Taxes							70,731	70,731			33
34	Rent-Facility & Grounds			446,760	446,760		446,760	(440,113)	6,647			34
35	Rent-Equipment & Vehicles			28,860	28,860		28,860	11,766	40,626			35
36	Other (specify):*											36
37	TOTAL Ownership			520,319	520,319		520,319	(84,082)	436,237			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			348,159	348,159	157,689	505,848	183,419	689,267			39
40	Barber and Beauty Shops	6,260	201		6,461		6,461		6,461			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					174,949	174,949		174,949			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	6,260	201	348,159	354,620	332,638	687,258	183,419	870,677			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,538,177	545,981	2,122,801	5,206,959		5,206,959	302,883	5,509,842			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	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	(2,762)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(4,112)			17
18	Fines and Penalties				18
19	Entertainment	(1,310)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,274)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(77,283)			24
25	Fund Raising, Advertising and Promotional	(5,446)			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)	\$ (93,187)		\$	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)	396,070		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 396,070		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 302,883		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

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		(2,274)	19	11
12		(2,762)	32	12
13		(77,283)	27	13
14		(5,446)	20	14
15		(4,112)	20	15
16		0	27	16
17		(1,310)	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	(93,187)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Litchfield# 0048900

Report Period Beginning:

1/1/2020

Ending:

12/31/2020**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	4,489	0	0	0	0	0	0	0	0	4,489	1
2	Food Purchase	0	0	(16)	0	0	0	0	0	0	0	0	(16)	2
3	Housekeeping	0	0	5,984	0	0	0	0	0	0	0	0	5,984	3
4	Laundry	0	0	428	0	0	0	0	0	0	0	0	428	4
5	Heat and Other Utilities	0	0	1,425	0	0	0	0	0	0	0	0	1,425	5
6	Maintenance	0	0	17,464	0	0	0	0	0	0	0	0	17,464	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	29,774	0	0	0	0	0	0	0	0	29,774	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	(15,799)	23,244	0	0	0	0	0	0	0	0	7,445	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	5	0	0	0	0	0	0	0	0	5	11
12	Social Services	0	0	128	0	0	0	0	0	0	0	0	128	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	(15,799)	23,377	0	0	0	0	0	0	0	0	7,578	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	(2,274)	(250,848)	15,236	0	0	0	0	0	0	0	0	(237,886)	19
20	Fees, Subscriptions & Promotions	(9,558)	0	884	0	0	0	0	0	0	0	0	(8,674)	20
21	Clerical & General Office Expenses	0	0	382,962	0	0	0	0	0	0	0	0	382,962	21
22	Employee Benefits & Payroll Taxes	0	0	38,566	0	0	0	0	0	0	0	0	38,566	22
23	Inservice Training & Education	0	(72)	1,213	0	0	0	0	0	0	0	0	1,141	23
24	Travel and Seminar	(1,310)	0	4,789	0	0	0	0	0	0	0	0	3,479	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	63,889	0	0	0	0	0	0	0	0	63,889	26
27	Other (specify):*	(77,283)	0	0	0	0	0	0	0	0	0	0	(77,283)	27
28	TOTAL General Administration	(90,425)	(250,920)	507,539	0	0	0	0	0	0	0	0	166,194	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(90,425)	(266,719)	560,690	0	0	0	0	0	0	0	0	203,546	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Litchfield # 0048900 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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	177,228	0	21,588	0	0	0	0	0	0	0	198,816	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,762)	75,057	0	2,423	0	0	0	0	0	0	0	74,718	32
33	Real Estate Taxes	0	70,731	0	0	0	0	0	0	0	0	0	70,731	33
34	Rent-Facility & Grounds	0	(446,760)	0	6,647	0	0	0	0	0	0	0	(440,113)	34
35	Rent-Equipment & Vehicles	0	0	0	11,766	0	0	0	0	0	0	0	11,766	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,762)	(123,744)	0	42,424	0	0	0	0	0	0	0	(84,082)	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	183,246	0	173	0	0	0	0	0	0	0	183,419	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	183,246	0	173	0	0	0	0	0	0	0	183,419	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(93,187)	(207,217)	560,690	42,597	0	0	0	0	0	0	0	302,883	45

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
Main SNF Services LLC	100	Attached Following This Page		Heritage Operations G	Bloomington	Mgmt. Services
				Green Tree Pharmacy	Minonk	Pharmacy
				Heritage Manor Real E	Bloomington	Propert rental

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Adjustment for Related Organiza	\$	GreenTree Pharmacy		\$ (15,799)	\$ (15,799)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy		(72)	(72)	2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy		183,246	183,246	3
4	V	19	Adjustment for Related Organization	250,848	Heritage Operations Group, LLC			(250,848)	4
5	V								5
6	V	34	Adjustment for Related Organization	446,760	Heritage Manor Real Estate, LLC			(446,760)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		70,731	70,731	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		74,845	74,845	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		177,228	177,228	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		212	212	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 697,608			\$ 490,391	\$ * (207,217)	14

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Heritage Operations Group		\$ 4,489	\$ 4,489	15
16	V	2	Food Purchase		Heritage Operations Group		(16)	(16)	16
17	V	3	Housekeeping		Heritage Operations Group		5,984	5,984	17
18	V	4	Laundry		Heritage Operations Group		428	428	18
19	V	5	Heat & Other Utilities		Heritage Operations Group		1,425	1,425	19
20	V	6	Maintenance		Heritage Operations Group		17,464	17,464	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		23,244	23,244	23
24	V	11	Activities		Heritage Operations Group		5	5	24
25	V	12	Social Service		Heritage Operations Group		128	128	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		15,236	15,236	31
32	V	20	Fees, Subscription, Promotions		Heritage Operations Group		884	884	32
33	V	21	Clerical & General Office Expenses		Heritage Operations Group		382,962	382,962	33
34	V	22	Employee Benefits & Payroll Taxes		Heritage Operations Group		38,566	38,566	34
35	V	23	Inservice Training & Education		Heritage Operations Group		1,213	1,213	35
36	V	24	Travel and Seminar		Heritage Operations Group		4,789	4,789	36
37	V	25	Other Admin. Staff Transportation		Heritage Operations Group		0		37
38	V	26	Insurance-Prop.Liab.Malpract		Heritage Operations Group		63,889	63,889	38
39	Total			\$			\$ 560,690	\$ * 560,690	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27		\$	Heritage Operations Group		\$ 0	\$	15
16	V	30			Heritage Operations Group		21,588	21,588	16
17	V	31			Heritage Operations Group		0		17
18	V	32			Heritage Operations Group		2,423	2,423	18
19	V	33			Heritage Operations Group		0		19
20	V	34			Heritage Operations Group		6,647	6,647	20
21	V	35			Heritage Operations Group		11,766	11,766	21
22	V	36			Heritage Operations Group		0		22
23	V	38			Heritage Operations Group		0		23
24	V	39			Heritage Operations Group		173	173	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			\$			\$ 42,597	\$ * 42,597	39

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

Facility Name & ID Number Heritage Health Litchfield # 0048900 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Main 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 Litchfield# 0048900

Report Period Beginning:

1/1/2020Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Heritage Operations Group

Street Address

115 W Jefferson Street

City / State / Zip Code

Bloomington, IL 61701

Phone Number

(309 828-4361

Fax Number

(309 829-5477

	1 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	92	\$ 4,489	1
2	2	Food Purchase	Beds	2,493	25	(423)	0	92	(16)	2
3	3	Housekeeping	Beds	2,493	25	162,156	0	92	5,984	3
4	4	Laundry	Beds	2,493	25	11,591	0	92	428	4
5	5	Heat & Other Utilities	Beds	2,493	25	38,605	0	92	1,425	5
6	6	Maintenance	Beds	2,493	25	473,233	88,567	92	17,464	6
7	7	Other	Beds	2,493	25	0	0	92	0	7
8	9	Medical Director	Beds	2,493	25	0	0	92	0	8
9	10	Nursing & Medical Records	Beds	2,493	25	629,872	35,401	92	23,244	9
10	11	Activities	Beds	2,493	25	129	0	92	5	10
11	12	Social Service	Beds	2,493	25	3,478	3,478	92	128	11
12	13	Nurse Aide Training	Beds	2,493	25	0	0	92	0	12
13	14	Program Transportation	Beds	2,493	25	0	0	92	0	13
14	15	Other	Beds	2,493	25	0	0	92	0	14
15	17	Administrative	Beds	2,493	25	0	0	92	0	15
16	18	Directors Fees	Beds	2,493	25	0	0	92	0	16
17	19	Professional Services	Beds	2,493	25	412,869	0	92	15,236	17
18	20	Fees, Subscription, Promotions	Beds	2,493	25	23,945	0	92	884	18
19	21	Clerical & General Office Expense	Beds	2,493	25	10,377,428	9,978,005	92	382,962	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,493	25	1,045,059	0	92	38,566	20
21	23	Inservice Training & Education	Beds	2,493	25	32,865	0	92	1,213	21
22	24	Travel and Seminar	Beds	2,493	25	129,776	0	92	4,789	22
23	25	Other Admin. Staff Transportation	Beds	2,493	25	0	0	92	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,493	25	1,731,253	0	92	63,889	24
25	TOTALS					\$ 15,193,470	\$ 10,226,789		\$ 560,690	25

Ending: 2/31/2020

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

IL478-2471

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			\$				\$ 74,845	1
2	Busey Bank		xx	Loan Fee Amortization							212	2
3												3
4												4
5												5
	Working Capital											
6	Busey Bank		xx	Working Capital							44,699	6
7												7
8												8
9	TOTAL Facility Related						\$				\$ 119,756	9
	B. Non-Facility Related*											
10	Interest Income										(2,762)	10
11												11
12	Allocated Corporate										2,423	12
13												13
14	TOTAL Non-Facility Related						\$				\$ (339)	14
15	TOTALS (line 9+line14)						\$				\$ 119,417	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2019 report.		\$		1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	70,731	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	70,731	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.		\$	70,731	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2015	74,457	8		
	2016	76,563	9		
	2017	78,056	10		
	2018	78,070	11		
	2019	70,731	12		
				FOR BHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2019 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

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

FACILITY NAME Heritage Health Litchfield COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0048900

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

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.

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.)

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.

A. Square Feet: 27,500

B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☐ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

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

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1996	\$ 6,816	1
2					2
3	TOTALS			\$ 6,816	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	92				\$ 3,364,350	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	1996 Improvements			1996	5,192					9
10	1997 Improvements			1997	13,647					10
11	1998 Improvements			1998	66,554					11
12	1999 Improvements			1999	15,346					12
13	2000 Improvements			2000	13,273					13
14	2001 Improvements			2001	4,860					14
15	2002 Improvements			2002	6,820					15
16	2003 Improvements			2003	13,771					16
17	2004 Improvements			2004	47,596					17
18	2005 Improvements			2005	135,427					18
19	2006 Improvements			2006	105,774					19
20	2007 Improvements			2007	52,894					20
21	2008 Improvements			2008	86,096					21
22	2009 Improvements			2009	524,594					22
23	2010 Improvements			2010	36,378					23
24	2011 Improvements			2011	66,259					24
25	2012 Improvements			2012	9,373					25
26	2013 Improvements			2013	13,380					26
27	2014 Improvements			2014	37,293					27
28										28
29	Replace (5) PTAC units			2015	2,885					29
30	Exterior brick repair - cut outs and replacments			2015	11,760					30
31	Furnish and install a roof fitted exhaust fan			2015	5,832					31
32										32
33										33
34	C/O Allocation					21,588		21,588		34
35	Book Depreciation					164,667		164,667		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 Litchfield

0048900

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38	2016							38
39								39
40	2017	3,229						40
41								41
42	2018	3,632						42
43	2018	32,574						43
44								44
45								45
46								46
47	2019	5,351						47
48	2019	2,535						48
49	2019	16,839						49
50	2019	37,158						50
51								51
52	2020	3,126						52
53	2020	17,800						53
54	2020	15,589						54
55	2020	99,582						55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70		\$ 4,876,769	\$ 186,255		\$ 186,255	\$	\$	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$836,410	\$12,561	\$12,561	\$		\$	71
72	Current Year Purchases	15,787						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$852,197	\$12,561	\$12,561	\$		\$	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		2009 Turtletop bus	2008	\$60,815	\$	\$	\$		\$
77		2008 Grand Caravan	2011	31,061					
78									
79									
80	TOTALS			\$91,876	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	5,827,658
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	198,816
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	198,816
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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.

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.

		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:

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$28,860Description:Televisions and office machines
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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)		1,342		1,342
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 1,342	\$	\$ 1,342
10	SUM OF line 9, col. 1 and 2 (e)	\$ 1,342			

(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.

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	

(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	\$		\$ 121,414	\$		\$ 121,414	1
2	Licensed Speech and Language Development Therapist		hrs			60,663			60,663	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			166,082	146		166,228	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				137,537		137,537	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					20,152			20,152	13
14	TOTAL			\$		\$ 368,311	\$ 137,683		\$ 505,994	14

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,014	\$	1
2	Cash-Patient Deposits	18,825		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	24,018		3
4	Supply Inventory (priced at <u>FIFO</u>)	31,564		4
5	Short-Term Investments			5
6	Prepaid Insurance	3,541		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	2,290,121		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,369,083	\$	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)	\$ 2,369,083	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,825		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	247,229		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,433		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	<u>Bed Tax</u>	9,111		36
37	<u>Deferred Stimulus</u>	274,419		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 553,017	\$	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)	\$ 553,017	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,816,066	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,369,083	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,801,590	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,801,590	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	14,476	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)	\$ 14,476	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)	\$ 1,816,066	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Health Litchfield

0048900

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.

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,715,274	1
2	Discounts and Allowances for all Levels	(1,115,829)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,599,445	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,015,713	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,015,713	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	376,056	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	5,404	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	221,832	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	26	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 603,318	23
	D. Non-Operating Revenue		
24	Contributions	197	24
25	Interest and Other Investment Income***	2,762	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,959	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)	\$ 5,221,435	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	872,940	31
32	Health Care	2,180,795	32
33	General Administration	1,278,285	33
	B. Capital Expense		
34	Ownership	520,319	34
	C. Ancillary Expense		
35	Special Cost Centers	354,620	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)*	\$ 5,206,959	40
41	Income before Income Taxes (line 30 minus line 40)**	14,476	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 14,476	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	574	598	\$ 86,576	\$ 144.78	1
2	Assistant Director of Nursing	2,074	2,160	59,709	27.64	2
3	Registered Nurses	7,175	7,474	234,174	31.33	3
4	Licensed Practical Nurses	13,985	14,568	392,820	26.96	4
5	CNAs & Orderlies	52,272	54,450	940,254	17.27	5
6	CNA Trainees	148	154	1,342	8.71	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,989	2,072	63,803	30.79	8
9	Activity Director					9
10	Activity Assistants	3,369	3,509	44,110	12.57	10
11	Social Service Workers	1,951	2,033	46,400	22.82	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,350	14,948	203,163	13.59	15
16	Dishwashers					16
17	Maintenance Workers	3,850	4,011	71,428	17.81	17
18	Housekeepers	8,565	8,922	109,124	12.23	18
19	Laundry	3,785	3,943	40,551	10.28	19
20	Administrator	2,023	2,108	86,416	40.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,703	6,983	152,047	21.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Beauticians</u>	400	417	6,260	15.01	33
34	TOTAL (lines 1 - 33)	123,213	128,350	\$ 2,538,177 *	\$ 19.78	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 6,126	L1 C3	35
36	Medical Director		24,000	L9 C3	36
37	Medical Records Consultant		1,015	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,767	L10A C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		1,927	L12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 37,835		49

C. CONTRACT NURSES

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

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?
If YES, give association name and amount.

HCCI - \$6,440

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

Yes
Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
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?
If NO, attach a complete explanation.

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No

(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.
This amount is to be recorded on line 42 of Schedule V.

\$ 174,949

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No
- (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?
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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 0
Yes Indicate the amount. \$ 2,131

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$ 0

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

Yes
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.
Attach invoices and a summary of services for all architect and appraisal fees.

None Claimed

5,759	
13,779	
2,605	D
(1,776,887)	
534,481	
(2,327)	
(201,820)	
(1,615,725)	
RYNOLONG	D
OTHER	
1,378,400	
(2,745,000)	
(5,434)	
(1937)	
530,898	
86,478	
10,809	
41,373	
4,309	
2,385	
2,389	
10,809	
555	
65,527	
2,142	
2,452	
24,800	
33,307	
4,767	
1,277	
1,835,390	
167,670	
22,891	
21,803	
7,650	
259,849	
36,869	
12,888	
1,277	
1,835,390	
(28)	
65,528	
11,637	
14,982	
47,791	
4,267	
54,872	
17,519	
2,142	
5,457	
26,459	
181,254	
(2,327)	
1,832	
1,832	
1,832	
98,720	
98,720	
30,531	
222,814	
18,708	
18,708	
28,544	
71,455	
1,262	
11,887	
4,752	
1,056	
98,874	
5,015	
281	
186,867	
4,332	
121,454	
98,883	
9,365	
291	
44,688	
(2,762)	
1,152	
114,476	

Heritage Manor - Litchfield
IDPH ID# 48900
HFS Cost Report - December 31, 2020
Schedule V - Column 5 Reclassifications

1. Schedule V - Line 10a to Line 39 - Reclassifications

<u>Line Item</u>	
Purchased Drugs and Medications	\$ 137,537
Purchased Hospital Services	3,315
Purchased Laboratory Services	11,927
Purchased Radiology Services	4,910
Amount Reclassified to Line 39	\$ <u>157,689</u>

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

<u>Line Item</u>	
Provider Participation Fee - \$1.50	\$ (50,508)
Provider Assesment Fee - \$6.07	<u>(124,441)</u>
	\$ <u>(174,949)</u>
Provider Participation Fee	\$ <u>174,949</u>

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

<u>Line Item</u>	
Pharmacy Consulting Fees	\$ <u>4,767</u>