

		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: 0048108

Facility Name: Heritage Health Mendota

Address: 1201 First Avenue Mendota 61342
Number City Zip Code

County: LaSalle

Telephone Number: (815) 539-6745 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: July 2007

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) David M Underwood
(Title) EVP & CFO

Paid
Preparer

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

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

Facility Name & ID NumberHeritage Health Mendota

#0048108Report Period Beginning:1/1/2020Ending: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	85	Skilled (SNF)	85	31,110
2		Skilled Pediatric (SNF/PED)		
3		Intermediate (ICF)		
4		Intermediate/DD		
5		Sheltered Care (SC)		
6		ICF/DD 16 or Less		
7	85	TOTALS	85	31,110

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	12,567	7,990	2,608	23,165	8
9 SNF/PED					9
10 ICF					10
11 ICF/DD					11
12 SC					12
13 DD 16 OR LESS					13
14 TOTALS	12,567	7,990	2,608	23,165	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)74.46%

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 NOxx

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NOxx

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

J. Was the facility purchased or leased after January 1, 1978?
YES Date NOxx

K. Was the facility certified for Medicare during the reporting year?
YESxxNO If YES, enter number of beds certified85 and days of care provided2,608

Medicare IntermediaryWPS

IV. ACCOUNTING BASIS

ACCUALxxMODIFIED CASH* CASH*

Is your fiscal year identical to your tax year?YESxxNO

Tax Year:Fiscal Year:

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Heritage Health Mendota # 0048108 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					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	201,472	18,655	6,203	226,330		226,330	4,147	230,477			1
2	Food Purchase		200,127		200,127		200,127	(14)	200,113			2
3	Housekeeping	74,133	25,829		99,962		99,962	5,529	105,491			3
4	Laundry	71,361	14,116		85,477		85,477	395	85,872			4
5	Heat and Other Utilities			73,866	73,866		73,866	1,316	75,182			5
6	Maintenance	80,429	58,863	91,321	230,613		230,613	16,135	246,748			6
7	Other (specify):*											7
8	TOTAL General Services	427,395	317,590	171,390	916,375		916,375	27,508	943,883			8
	B. Health Care and Programs											
9	Medical Director			12,039	12,039		12,039		12,039			9
10	Nursing and Medical Records	2,269,612	162,497	58,814	2,490,923	(4,872)	2,486,051	1,757	2,487,808			10
10a	Therapy		146,232	33,877	180,109	(175,237)	4,872		4,872			10a
11	Activities	87,453	541		87,994		87,994	4	87,998			11
12	Social Services	41,816		5,928	47,744		47,744	119	47,863			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,398,881	309,270	110,658	2,818,809	(180,109)	2,638,700	1,880	2,640,580			16
	C. General Administration											
17	Administrative	100,504			100,504		100,504		100,504			17
18	Directors Fees											18
19	Professional Services			326,740	326,740		326,740	(309,734)	17,006			19
20	Dues, Fees, Subscriptions & Promotions			201,440	201,440	(179,944)	21,496	(9,863)	11,633			20
21	Clerical & General Office Expenses	221,192	23,286	8,967	253,445		253,445	353,823	607,268			21
22	Employee Benefits & Payroll Taxes			541,465	541,465		541,465	35,632	577,097			22
23	Inservice Training & Education			36	36		36	1,085	1,121			23
24	Travel and Seminar			1,686	1,686		1,686	3,313	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			47,874	47,874		47,874	59,028	106,902			26
27	Other (specify):* Lost resident items			79,095	79,095		79,095	(79,095)				27
28	TOTAL General Administration	321,696	23,286	1,207,303	1,552,285	(179,944)	1,372,341	54,189	1,426,530			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,147,972	650,146	1,489,351	5,287,469	(360,053)	4,927,416	83,577	5,010,993			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							132,178	132,178			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			41,297	41,297		41,297	49,324	90,621			32
33	Real Estate Taxes							48,585	48,585			33
34	Rent-Facility & Grounds			435,420	435,420		435,420	(427,479)	7,941			34
35	Rent-Equipment & Vehicles			22,814	22,814		22,814	10,871	33,685			35
36	Other (specify):*											36
37	TOTAL Ownership			499,531	499,531		499,531	(186,521)	313,010			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			578,365	578,365	180,109	758,474	162,749	921,223			39
40	Barber and Beauty Shops			2,850	2,850		2,850		2,850			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					179,944	179,944		179,944			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			581,215	581,215	360,053	941,268	162,749	1,104,017			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,147,972	650,146	2,570,097	6,368,215		6,368,215	59,805	6,428,020			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	(1,834)			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	(3,945)			17
18	Fines and Penalties				18
19	Entertainment	(1,112)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(15,398)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(79,095)			24
25	Fund Raising, Advertising and Promotional	(6,734)			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)	\$ (108,118)		\$	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)	167,923		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 167,923		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 59,805		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		(15,398)	19	11
12		(1,834)	32	12
13		(79,095)	27	13
14		(6,734)	20	14
15		(3,945)	20	15
16		0	34	16
17		(1,112)	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	(108,118)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Mendota# 0048108

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	4,147	0	0	0	0	0	0	0	0	4,147	1
2	Food Purchase	0	0	(14)	0	0	0	0	0	0	0	0	(14)	2
3	Housekeeping	0	0	5,529	0	0	0	0	0	0	0	0	5,529	3
4	Laundry	0	0	395	0	0	0	0	0	0	0	0	395	4
5	Heat and Other Utilities	0	0	1,316	0	0	0	0	0	0	0	0	1,316	5
6	Maintenance	0	0	16,135	0	0	0	0	0	0	0	0	16,135	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	27,508	0	0	0	0	0	0	0	0	27,508	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	(19,719)	21,476	0	0	0	0	0	0	0	0	1,757	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	4	0	0	0	0	0	0	0	0	4	11
12	Social Services	0	0	119	0	0	0	0	0	0	0	0	119	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	(19,719)	21,599	0	0	0	0	0	0	0	0	1,880	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	(15,398)	(308,413)	14,077	0	0	0	0	0	0	0	0	(309,734)	19
20	Fees, Subscriptions & Promotions	(10,679)	0	816	0	0	0	0	0	0	0	0	(9,863)	20
21	Clerical & General Office Expenses	0	0	353,823	0	0	0	0	0	0	0	0	353,823	21
22	Employee Benefits & Payroll Taxes	0	0	35,632	0	0	0	0	0	0	0	0	35,632	22
23	Inservice Training & Education	0	(36)	1,121	0	0	0	0	0	0	0	0	1,085	23
24	Travel and Seminar	(1,112)	0	4,425	0	0	0	0	0	0	0	0	3,313	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	59,028	0	0	0	0	0	0	0	0	59,028	26
27	Other (specify):*	(79,095)	0	0	0	0	0	0	0	0	0	0	(79,095)	27
28	TOTAL General Administration	(106,284)	(308,449)	468,922	0	0	0	0	0	0	0	0	54,189	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(106,284)	(328,168)	518,029	0	0	0	0	0	0	0	0	83,577	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Mendota # 0048108 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	112,233	0	19,945	0	0	0	0	0	0	0	132,178	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,834)	48,919	0	2,239	0	0	0	0	0	0	0	49,324	32
33	Real Estate Taxes	0	48,585	0	0	0	0	0	0	0	0	0	48,585	33
34	Rent-Facility & Grounds	0	(433,620)	0	6,141	0	0	0	0	0	0	0	(427,479)	34
35	Rent-Equipment & Vehicles	0	0	0	10,871	0	0	0	0	0	0	0	10,871	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,834)	(223,883)	0	39,196	0	0	0	0	0	0	0	(186,521)	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	162,589	0	160	0	0	0	0	0	0	0	162,749	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	162,589	0	160	0	0	0	0	0	0	0	162,749	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(108,118)	(389,462)	518,029	39,356	0	0	0	0	0	0	0	59,805	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
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.

☒ 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		\$ (19,719)	\$ (19,719)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy		(36)	(36)	2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy		162,589	162,589	3
4	V	19	Adjustment for Related Organization	308,413	Heritage Operations Group, LLC			(308,413)	4
5	V								5
6	V	34	Adjustment for Related Organization	433,620	Heritage Manor Real Estate, LLC			(433,620)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		48,585	48,585	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		46,142	46,142	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		112,233	112,233	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		2,777	2,777	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 742,033			\$ 352,571	\$ * (389,462)	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		\$ 4,147	\$ 4,147	15
16	V	2	Food Purchase		Heritage Operations Group		(14)	(14)	16
17	V	3	Housekeeping		Heritage Operations Group		5,529	5,529	17
18	V	4	Laundry		Heritage Operations Group		395	395	18
19	V	5	Heat & Other Utilities		Heritage Operations Group		1,316	1,316	19
20	V	6	Maintenance		Heritage Operations Group		16,135	16,135	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		21,476	21,476	23
24	V	11	Activities		Heritage Operations Group		4	4	24
25	V	12	Social Service		Heritage Operations Group		119	119	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		14,077	14,077	31
32	V	20	Fees, Subscription, Promotions		Heritage Operations Group		816	816	32
33	V	21	Clerical & General Office Expenses		Heritage Operations Group		353,823	353,823	33
34	V	22	Employee Benefits & Payroll Taxes		Heritage Operations Group		35,632	35,632	34
35	V	23	Inservice Training & Education		Heritage Operations Group		1,121	1,121	35
36	V	24	Travel and Seminar		Heritage Operations Group		4,425	4,425	36
37	V	25	Other Admin. Staff Transportation		Heritage Operations Group		0		37
38	V	26	Insurance-Prop.Liab.Malpract		Heritage Operations Group		59,028	59,028	38
39	Total			\$			\$ 518,029	\$ * 518,029	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.

☒ XX

 YES

☐

 NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27		\$	Heritage Operations Group		\$ 0	\$	15
16	V	30			Heritage Operations Group		19,945	19,945	16
17	V	31			Heritage Operations Group		0		17
18	V	32			Heritage Operations Group		2,239	2,239	18
19	V	33			Heritage Operations Group		0		19
20	V	34			Heritage Operations Group		6,141	6,141	20
21	V	35			Heritage Operations Group		10,871	10,871	21
22	V	36			Heritage Operations Group		0		22
23	V	38			Heritage Operations Group		0		23
24	V	39			Heritage Operations Group		160	160	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			\$			\$ 39,356	\$ * 39,356	39

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

Facility Name & ID Number Heritage Health Mendota # 0048108 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	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 Mendota# 0048108

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,493	25	\$ 121,634	\$ 121,338	85	\$ 4,147	1
2	2	Food Purchase	Beds	2,493	25	(423)	0	85	(14)	2
3	3	Housekeeping	Beds	2,493	25	162,156	0	85	5,529	3
4	4	Laundry	Beds	2,493	25	11,591	0	85	395	4
5	5	Heat & Other Utilities	Beds	2,493	25	38,605	0	85	1,316	5
6	6	Maintenance	Beds	2,493	25	473,233	88,567	85	16,135	6
7	7	Other	Beds	2,493	25	0	0	85	0	7
8	9	Medical Director	Beds	2,493	25	0	0	85	0	8
9	10	Nursing & Medical Records	Beds	2,493	25	629,872	35,401	85	21,476	9
10	11	Activities	Beds	2,493	25	129	0	85	4	10
11	12	Social Service	Beds	2,493	25	3,478	3,478	85	119	11
12	13	Nurse Aide Training	Beds	2,493	25	0	0	85	0	12
13	14	Program Transportation	Beds	2,493	25	0	0	85	0	13
14	15	Other	Beds	2,493	25	0	0	85	0	14
15	17	Administrative	Beds	2,493	25	0	0	85	0	15
16	18	Directors Fees	Beds	2,493	25	0	0	85	0	16
17	19	Professional Services	Beds	2,493	25	412,869	0	85	14,077	17
18	20	Fees, Subscription, Promotions	Beds	2,493	25	23,945	0	85	816	18
19	21	Clerical & General Office Expense	Beds	2,493	25	10,377,428	9,978,005	85	353,823	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,493	25	1,045,059	0	85	35,632	20
21	23	Inservice Training & Education	Beds	2,493	25	32,865	0	85	1,121	21
22	24	Travel and Seminar	Beds	2,493	25	129,776	0	85	4,425	22
23	25	Other Admin. Staff Transportation	Beds	2,493	25	0	0	85	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,493	25	1,731,253	0	85	59,028	24
25	TOTALS					\$ 15,193,470	\$ 10,226,789		\$ 518,029	25

Facility Name & ID Number Heritage Health Mendota # 0048108 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 ☒ 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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,493	25	\$	\$	85	\$	1
2	30	Depreciation	Beds	2,493	25	584,981		85	19,945	2
3	31	Amortization of Pre-Op & Org	Beds	2,493	25			85		3
4	32	Interest	Beds	2,493	25	65,658		85	2,239	4
5	33	Real Estate Taxes	Beds	2,493	25			85		5
6	34	Rent-Facility & Grounds	Beds	2,493	25	180,106		85	6,141	6
7	35	Rent-Equipment & Vehicles	Beds	2,493	25	318,843		85	10,871	7
8	36	Other	Beds	2,493	25			85		8
9	38	Medically Nec Transportation	Beds	2,493	25			85		9
10	39	Ancillary Service Centers	Beds	2,493	25	4,685		85	160	10
11	40	Barber and Beauty Shops	Beds	2,493	25			85		11
12	41	Coffee and Gift Shops	Beds	2,493	25			85		12
13	42	Other	Beds	2,493	25			85		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	\$		\$ 39,356	25

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			\$					\$ 46,142	1
2	Busey Bank		xx	Loan Fee Amortization								2,777	2
3													3
4													4
5													5
	Working Capital												
6	Busey Bank		xx	Working Capital								41,297	6
7													7
8													8
9	TOTAL Facility Related						\$					\$ 90,216	9
	B. Non-Facility Related*												
10	Interest Income											(1,834)	10
11													11
12	Allocated Corporate											2,239	12
13													13
14	TOTAL Non-Facility Related						\$					\$ 405	14
15	TOTALS (line 9+line14)						\$					\$ 90,621	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

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.)			\$48,585	2
3. Under or (over) accrual (line 2 minus line 1).			\$48,585	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.			\$48,585	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2015	51,857	8	
	2016	51,614	9	
	2017	51,147	10	
	2018	49,846	11	
	2019	48,585	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 Mendota COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0048108

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.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

26,580

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				\$ 26,150	1
2					2
3	TOTALS			\$ 26,150	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	85		1980	1965	\$ 697,500	\$		\$		4
5			1985	1985	408,657					5
6										6
7										7
8										8
	Improvement Type**									
9										9
10		1980 Improvements		1980	8,150					10
11		1981 Improvements		1981	20,492					11
12		1982 Improvements		1982	9,185					12
13		1983 Improvements		1983	5,682					13
14		1984 Improvements		1984	11,488					14
15		1985 Improvements		1985	7,710					15
16		1986 Improvements		1986	2,255					16
17		1987 Improvements		1987	9,037					17
18		1988 Improvements		1988	21,297					18
19		1989 Improvements		1989	4,653					19
20		1990 Improvements		1990	36,595					20
21		1991 Improvements		1991						21
22		1992 Improvements		1992	10,646					22
23		1993 Improvements		1993	40,167					23
24		1994 Improvements		1994	10,869					24
25		1995 Improvements		1995	12,752					25
26		1996 Improvements		1996	19,498					26
27		1997 Improvements		1997	44,321					27
28		1998 Improvements		1998	11,771					28
29		1999 Improvements		1999	17,270					29
30		2000 Improvements		2000	391,392					30
31										31
32										32
33										33
34		C/O Allocation				19,945		19,945		34
35		Book Depreciation				87,064		87,064		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 Mendota

0048108

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 2001 Improvements	2001	\$ 4,299	\$		\$	\$	\$	37
38 2002 Improvements	2002	4,493						38
39 2003 Improvements	2003	6,927						39
40 2004 Improvements	2004	13,137						40
41 2005 Improvements	2005	90,752						41
42 2006 Improvements	2006	179,140						42
43 2007 Improvements	2007	216,052						43
44 2008 Improvements	2008	2,713						44
45 2009 Improvements	2009	46,518						45
46 2010 Improvements	2010	27,310						46
47 2011 Improvements	2011	3,513						47
48 2012 Improvements	2012	14,174						48
49 2013 Improvements	2013	15,794						49
50 2014 Improvements	2014	20,245						50
51								51
52 Installed (5) PTAC units								52
53								53
54 Install 100AMP emergency panel for dining room	2015	3,321						54
55 Install new shower room floor and attach new water lines								55
56	2016	4,500						56
57 Install HVAC unit	2016	13,884						57
58 Repalce water heater								58
59	2017	11,860						59
60	2017	6,656						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)		\$ 2,486,675	\$ 107,009		\$ 107,009	\$	\$	70

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

Facility Name & ID Number Heritage Health Mendota

0048108

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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,486,675	\$ 107,009		\$ 107,009			1
2									2
3	Replace PTAC units	2018	2,641						3
4									4
5	Replace (4) PTAC units	2019	2,777						5
6	Remodeling Project:	2019	289,852						6
7	Phase 1 - New flooring, millwork base, paint, lighting and								7
8	window treatments in front entry area. Salon, administrator office								8
9	care planning room, front entry nursing station and								9
10	living room.								10
11	Phase 2 - For 30 bathrooms provided new paint, ceiling tile, flooring, base								11
12	sinks&vanity tops, toilets, wall protection, new lighting								12
13	and new mirrors/cabinets, faucets, towel dispensers and grab bars								13
14									14
15	Replaced storage tank	2020	4,761						15
16	Replaced condensing unit	2020	3,962						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)		\$ 2,790,668	\$ 107,009		\$ 107,009			34

**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	\$1,146,268	\$25,169	\$25,169	\$		\$	71
72	Current Year Purchases	24,246						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,170,514	\$25,169	\$25,169	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$3,987,332	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$132,178	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$132,178	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.

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: *

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: \$ 22,814 Description: Televisions and copiers
(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)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (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.

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	

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	\$		\$ 225,801	\$		\$ 225,801	1
2	Licensed Speech and Language Development Therapist		hrs			101,277			101,277	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			251,287	0		251,287	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				146,232		146,232	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					33,877			33,877	13
14	TOTAL			\$		\$ 612,242	\$ 146,232		\$ 758,474	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	\$ 404	\$	1
2	Cash-Patient Deposits	18,851		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	313,924		3
4	Supply Inventory (priced at FIFO)	28,826		4
5	Short-Term Investments			5
6	Prepaid Insurance	734		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(687,162)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (324,423)	\$	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)	\$ (324,423)	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,851		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	277,217		30
31	Accrued Taxes Payable (excluding real estate taxes)	911		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	6,434		36
37	Deferred Stimulus	205,451		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 508,864	\$	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)	\$ 508,864	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (833,287)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (324,423)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (847,542)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (847,542)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	14,255	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)	\$ 14,255	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)	\$ (833,287)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Health Mendota

0048108

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	\$ 5,632,843	1
2	Discounts and Allowances for all Levels	(1,610,009)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,022,834	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,750,158	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,750,158	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	364,759	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,287	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	235,875	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	868	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 605,789	23
	D. Non-Operating Revenue		
24	Contributions	1,855	24
25	Interest and Other Investment Income***	1,834	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,689	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)	\$ 6,382,470	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	916,375	31
32	Health Care	2,818,809	32
33	General Administration	1,552,285	33
	B. Capital Expense		
34	Ownership	499,531	34
	C. Ancillary Expense		
35	Special Cost Centers	581,215	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)*	\$ 6,368,215	40
41	Income before Income Taxes (line 30 minus line 40)**	14,255	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 14,255	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	1,973	2,055	\$ 88,055	\$ 42.85	1
2	Assistant Director of Nursing	1,904	1,983	64,945	32.75	2
3	Registered Nurses	15,827	16,486	571,855	34.69	3
4	Licensed Practical Nurses	11,693	12,180	362,449	29.76	4
5	CNAs & Orderlies	66,173	68,930	1,182,308	17.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,507	6,778	87,453	12.90	10
11	Social Service Workers	1,846	1,923	41,816	21.75	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,677	16,330	201,472	12.34	15
16	Dishwashers					16
17	Maintenance Workers	3,787	3,945	80,429	20.39	17
18	Housekeepers	5,227	5,445	74,133	13.61	18
19	Laundry	5,418	5,644	71,361	12.64	19
20	Administrator	1,961	2,043	100,504	49.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,352	8,700	221,192	25.42	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)	146,345	152,442	\$ 3,147,972 *	\$ 20.65	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		\$ 6,203	L1 C3	35
36	Medical Director		12,039	L9 C3	36
37	Medical Records Consultant		493	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,872	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		5,928	L12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 29,535		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 17,500	L10 C3	50
51	Licensed Practical Nurses		20,806	L10 C3	51
52	Certified Nurse Assistants/Aides		15,143	L10 C3	52
53	TOTAL (lines 50 - 52)		\$ 53,449		53

Facility Name & ID Number

Heritage Health Mendota

STATE OF ILLINOIS

0048108

Report Period Beginning:

1/1/2020

Page 21

Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount	
Michelle Hansen		Administrator		\$ 100,504	Workers' Compensation Insurance		\$ 21,103	IDPH License Fee		\$	
					Unemployment Compensation Insurance		6,358	Advertising: Employee Recruitment		3,209	
					FICA Taxes		240,820	Health Care Worker Background Check			
					Employee Health Insurance		187,008	(Indicate # of checks performed)		1,772	
					Employee Meals			Patient Background Checks			
					Illinois Municipal Retirement Fund (IMRF)*						
								PR		1,439	
					Other Benefits		86,176	Dues & Subscriptions		6,920	
					Central Office Allocation		35,632	License & Fees		2,861	
								Central Office Allocation		816	
								Less: Public Relations Expense		(1,439)	
								Non-allowable advertising		(3,945)	
								Yellow page advertising (			
TOTAL (agree to Schedule V, line 17, col. 1)				\$ 100,504	TOTAL (agree to Schedule V, line 22, col.8)		\$ 577,097	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 11,633	
(List each licensed administrator separately.)											
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description			Amount	Description		Line #	Amount	Description		Amount	
			\$				\$	Out-of-State Travel		\$	
								In-State Travel			
										1,360	
										76	
								Seminar Expense		250	
										3,313	
								Entertainment Expense (			
								(agree to Sch. V, line 24, col. 8)			
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			\$	TOTAL		\$ 4,999	
(Attach a copy of any management service agreement)											
C. Professional Services											
Vendor/Payee		Type	Amount								
Heritage Operations Group		Management	\$ 311,342								
Legal adj to Zero			15,398								
TOTAL (agree to Schedule V, line 19, column 3)			\$ 326,740								
(For legal fee disclosure, see page 39 of instructions)											

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

XX. GENERAL INFORMATION:

- | | |
|---|---|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>Yes</u>
If YES, give association name and amount. <u>HCCI - \$5,950</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>Yes</u> If YES, have these costs been properly adjusted out of the cost report? <u>Yes</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? _____</p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u>
What was the average life used for new equipment added during this period? <u>7 Yrs</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>5,000</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u>
If YES, give effective date of lease. _____</p> <p>(9) Are you presently operating under a sublease agreement? YES <u>xx</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>xx</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
_____</p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>179,944</u>
This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation.</p> | <p>(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? <u>Yes</u></p> <p>(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? <u>No</u> 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.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>0</u> Has any meal income been offset against related costs? <u>Yes</u> Indicate the amount. \$ <u>492</u></p> <p>(16) Travel and Transportation
a. Are there costs included for out-of-state travel? <u>No</u>
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> 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? <u>100%</u>
d. Have vehicle usage logs been maintained? <u>Yes</u>
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>Yes</u>
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>NA</u>
g. Does the facility transport residents to and from day training? <u>No</u>
Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>0</u></p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>Yes</u>
Firm Name: <u>MCK CPA's & Advisors</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(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. <u>None Claimed</u>
Attach invoices and a summary of services for all architect and appraisal fees.</p> |
|---|---|

Heritage Manor - Mendota
IDPH ID# 48108
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	\$ 146,232
Purchased Hospital Services	5,878
Purchased Laboratory Services	25,003
Purchased Radiology Services	2,996
Amount Reclassified to Line 39	\$ <u>180,109</u>

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

<u>Line Item</u>	
Provider Participation Fee - \$1.50	\$ (46,665)
Provider Assesment Fee - \$6.07	<u>(133,279)</u>
	\$ <u>(179,944)</u>
 Provider Participation Fee	 \$ <u>179,944</u>

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

<u>Line Item</u>	
Pharmacy Consultant Fees	\$ <u>4,872</u>