

Facility Name & ID Number Heritage Health Minonk

0048058 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>49</u>	Skilled (SNF)	<u>49</u>	<u>17,934</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>23</u>	Sheltered Care (SC)	<u>23</u>	<u>8,418</u>	5
6		ICF/DD 16 or Less			6
7	<u>72</u>	TOTALS	<u>72</u>	<u>26,352</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>4,450</u>	<u>5,292</u>	<u>1,839</u>	<u>11,581</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		<u>3,561</u>		<u>3,561</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>4,450</u>	<u>8,853</u>	<u>1,839</u>	<u>15,142</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.46%

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 ☐ 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 2006

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 49 and days of care provided 1,839

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL ☒ 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 Minonk # 0048058 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	184,985	15,559	4,685	205,229		205,229	3,513	208,742			1
2	Food Purchase		127,131		127,131		127,131	(12)	127,119			2
3	Housekeeping	50,464	17,640		68,104		68,104	4,683	72,787			3
4	Laundry	40,956	8,154		49,110		49,110	335	49,445			4
5	Heat and Other Utilities			67,478	67,478		67,478	1,115	68,593			5
6	Maintenance	65,723	46,636	74,956	187,315		187,315	13,667	200,982			6
7	Other (specify):*											7
8	TOTAL General Services	342,128	215,120	147,119	704,367		704,367	23,301	727,668			8
	B. Health Care and Programs											
9	Medical Director			7,150	7,150		7,150		7,150			9
10	Nursing and Medical Records	1,196,943	84,791	40,090	1,321,824	(3,521)	1,318,303	542	1,318,845			10
10a	Therapy		132,382	38,688	171,070	(167,294)	3,776		3,776			10a
11	Activities	63,828	3,732		67,560		67,560	4	67,564			11
12	Social Services	47,875		1,657	49,532		49,532	100	49,632			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,308,646	220,905	87,585	1,617,136	(170,815)	1,446,321	646	1,446,967			16
	C. General Administration											
17	Administrative	81,447			81,447		81,447		81,447			17
18	Directors Fees											18
19	Professional Services			202,144	202,144		202,144	(188,457)	13,687			19
20	Dues, Fees, Subscriptions & Promotions			109,206	109,206	(88,839)	20,367	(9,475)	10,892			20
21	Clerical & General Office Expenses	136,866	29,243	6,567	172,676		172,676	299,709	472,385			21
22	Employee Benefits & Payroll Taxes			303,831	303,831		303,831	30,182	334,013			22
23	Inservice Training & Education			201	201		201	949	1,150			23
24	Travel and Seminar			3,924	3,924		3,924	1,075	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			36,190	36,190		36,190	50,000	86,190			26
27	Other (specify):* Lost resident items			(21,420)	(21,420)		(21,420)	21,503	83			27
28	TOTAL General Administration	218,313	29,243	640,643	888,199	(88,839)	799,360	205,486	1,004,846			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,869,087	465,268	875,347	3,209,702	(259,654)	2,950,048	229,433	3,179,481			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							181,582	181,582			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,807	23,807		23,807	27,326	51,133			32
33	Real Estate Taxes							32,506	32,506			33
34	Rent-Facility & Grounds			315,360	315,360		315,360	(310,158)	5,202			34
35	Rent-Equipment & Vehicles			41,928	41,928		41,928	9,208	51,136			35
36	Other (specify):*											36
37	TOTAL Ownership			381,095	381,095		381,095	(59,536)	321,559			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			446,590	446,590	170,815	617,405	100,060	717,465			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					88,839	88,839		88,839			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			446,590	446,590	259,654	706,244	100,060	806,304			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,869,087	465,268	1,703,032	4,037,387		4,037,387	269,957	4,307,344			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	(491)			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	(3,037)			17
18	Fines and Penalties				18
19	Entertainment	(2,673)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,164)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	21,503			24
25	Fund Raising, Advertising and Promotional	(7,130)			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)	\$ 2,008		\$	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)	267,949		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 267,949		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 269,957		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		(6,164)	19	11
12		(491)	32	12
13		21,503	27	13
14		(7,130)	20	14
15		(3,037)	20	15
16		0	27	16
17		(2,673)	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	2,008		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Minonk# 0048058

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	3,513	0	0	0	0	0	0	0	0	3,513	1
2	Food Purchase	0	0	(12)	0	0	0	0	0	0	0	0	(12)	2
3	Housekeeping	0	0	4,683	0	0	0	0	0	0	0	0	4,683	3
4	Laundry	0	0	335	0	0	0	0	0	0	0	0	335	4
5	Heat and Other Utilities	0	0	1,115	0	0	0	0	0	0	0	0	1,115	5
6	Maintenance	0	0	13,667	0	0	0	0	0	0	0	0	13,667	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	23,301	0	0	0	0	0	0	0	0	23,301	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	(17,649)	18,191	0	0	0	0	0	0	0	0	542	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	100	0	0	0	0	0	0	0	0	100	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	(17,649)	18,295	0	0	0	0	0	0	0	0	646	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	(6,164)	(194,217)	11,924	0	0	0	0	0	0	0	0	(188,457)	19
20	Fees, Subscriptions & Promotions	(10,167)	0	692	0	0	0	0	0	0	0	0	(9,475)	20
21	Clerical & General Office Expenses	0	0	299,709	0	0	0	0	0	0	0	0	299,709	21
22	Employee Benefits & Payroll Taxes	0	0	30,182	0	0	0	0	0	0	0	0	30,182	22
23	Inservice Training & Education	0	0	949	0	0	0	0	0	0	0	0	949	23
24	Travel and Seminar	(2,673)	0	3,748	0	0	0	0	0	0	0	0	1,075	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	50,000	0	0	0	0	0	0	0	0	50,000	26
27	Other (specify):*	21,503	0	0	0	0	0	0	0	0	0	0	21,503	27
28	TOTAL General Administration	2,499	(194,217)	397,204	0	0	0	0	0	0	0	0	205,486	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	2,499	(211,866)	438,800	0	0	0	0	0	0	0	0	229,433	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Minonk # 0048058 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	164,687	0	16,895	0	0	0	0	0	0	0	181,582	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(491)	25,921	0	1,896	0	0	0	0	0	0	0	27,326	32
33	Real Estate Taxes	0	32,506	0	0	0	0	0	0	0	0	0	32,506	33
34	Rent-Facility & Grounds	0	(315,360)	0	5,202	0	0	0	0	0	0	0	(310,158)	34
35	Rent-Equipment & Vehicles	0	0	0	9,208	0	0	0	0	0	0	0	9,208	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(491)	(92,246)	0	33,201	0	0	0	0	0	0	0	(59,536)	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	99,925	0	135	0	0	0	0	0	0	0	100,060	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	99,925	0	135	0	0	0	0	0	0	0	100,060	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,008	(204,187)	438,800	33,336	0	0	0	0	0	0	0	269,957	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
Center SNF Services LLC	100	Attached Following This Page		Heritage Operations G	Bloomington	Mgmt. Services
				Green Tree Pharmacy	Minonk	Pharmacy
				Heritage Manor Real E	Bloomington	Propert rental

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

☒ 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		\$ (17,649)	\$ (17,649)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy				2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy		99,925	99,925	3
4	V	19	Adjustment for Related Organization	194,217	Heritage Operations Group, LLC			(194,217)	4
5	V								5
6	V	34	Adjustment for Related Organization	315,360	Heritage Manor Real Estate, LLC			(315,360)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		32,506	32,506	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		24,450	24,450	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		164,687	164,687	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		1,471	1,471	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 509,577			\$ 305,390	\$ * (204,187)	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		\$ 3,513	\$ 3,513	15
16	V	2	Food Purchase		Heritage Operations Group		(12)	(12)	16
17	V	3	Housekeeping		Heritage Operations Group		4,683	4,683	17
18	V	4	Laundry		Heritage Operations Group		335	335	18
19	V	5	Heat & Other Utilities		Heritage Operations Group		1,115	1,115	19
20	V	6	Maintenance		Heritage Operations Group		13,667	13,667	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		18,191	18,191	23
24	V	11	Activities		Heritage Operations Group		4	4	24
25	V	12	Social Service		Heritage Operations Group		100	100	25
26	V	13	Nurse Aide Training		Heritage Operations Group		0		26
27	V	14	Program Transportation		Heritage Operations Group		0		27
28	V	15	Other		Heritage Operations Group		0		28
29	V	17	Administrative		Heritage Operations Group		0		29
30	V	18	Directors Fees		Heritage Operations Group		0		30
31	V	19	Professional Services		Heritage Operations Group		11,924	11,924	31
32	V	20	Fees, Subscription, Promotions		Heritage Operations Group		692	692	32
33	V	21	Clerical & General Office Expenses		Heritage Operations Group		299,709	299,709	33
34	V	22	Employee Benefits & Payroll Taxes		Heritage Operations Group		30,182	30,182	34
35	V	23	Inservice Training & Education		Heritage Operations Group		949	949	35
36	V	24	Travel and Seminar		Heritage Operations Group		3,748	3,748	36
37	V	25	Other Admin. Staff Transportation		Heritage Operations Group		0		37
38	V	26	Insurance-Prop.Liab.Malpract		Heritage Operations Group		50,000	50,000	38
39	Total			\$			\$ 438,800	\$ * 438,800	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		16,895	16,895	16
17	V	31			Heritage Operations Group		0		17
18	V	32			Heritage Operations Group		1,896	1,896	18
19	V	33			Heritage Operations Group		0		19
20	V	34			Heritage Operations Group		5,202	5,202	20
21	V	35			Heritage Operations Group		9,208	9,208	21
22	V	36			Heritage Operations Group		0		22
23	V	38			Heritage Operations Group		0		23
24	V	39			Heritage Operations Group		135	135	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			\$			\$ 33,336	\$ * 33,336	39

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

Facility Name & ID Number Heritage Health Minonk # 0048058 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	Center SNF Services LLC			100.00	0	0			\$ 0		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Heritage Health Minonk# 0048058

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	72	\$ 3,513	1
2	2	Food Purchase	Beds	2,493	25	(423)	0	72	(12)	2
3	3	Housekeeping	Beds	2,493	25	162,156	0	72	4,683	3
4	4	Laundry	Beds	2,493	25	11,591	0	72	335	4
5	5	Heat & Other Utilities	Beds	2,493	25	38,605	0	72	1,115	5
6	6	Maintenance	Beds	2,493	25	473,233	88,567	72	13,667	6
7	7	Other	Beds	2,493	25	0	0	72	0	7
8	9	Medical Director	Beds	2,493	25	0	0	72	0	8
9	10	Nursing & Medical Records	Beds	2,493	25	629,872	35,401	72	18,191	9
10	11	Activities	Beds	2,493	25	129	0	72	4	10
11	12	Social Service	Beds	2,493	25	3,478	3,478	72	100	11
12	13	Nurse Aide Training	Beds	2,493	25	0	0	72	0	12
13	14	Program Transportation	Beds	2,493	25	0	0	72	0	13
14	15	Other	Beds	2,493	25	0	0	72	0	14
15	17	Administrative	Beds	2,493	25	0	0	72	0	15
16	18	Directors Fees	Beds	2,493	25	0	0	72	0	16
17	19	Professional Services	Beds	2,493	25	412,869	0	72	11,924	17
18	20	Fees, Subscription, Promotions	Beds	2,493	25	23,945	0	72	692	18
19	21	Clerical & General Office Expense	Beds	2,493	25	10,377,428	9,978,005	72	299,709	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,493	25	1,045,059	0	72	30,182	20
21	23	Inservice Training & Education	Beds	2,493	25	32,865	0	72	949	21
22	24	Travel and Seminar	Beds	2,493	25	129,776	0	72	3,748	22
23	25	Other Admin. Staff Transportation	Beds	2,493	25	0	0	72	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,493	25	1,731,253	0	72	50,000	24
25	TOTALS					\$ 15,193,470	\$ 10,226,789		\$ 438,800	25

Facility Name & ID Number Heritage Health Minonk # 0048058 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	\$	\$	72	\$	1
2	30	Depreciation	Beds	2,493	25	584,981		72	16,895	2
3	31	Amortization of Pre-Op & Org	Beds	2,493	25			72		3
4	32	Interest	Beds	2,493	25	65,658		72	1,896	4
5	33	Real Estate Taxes	Beds	2,493	25			72		5
6	34	Rent-Facility & Grounds	Beds	2,493	25	180,106		72	5,202	6
7	35	Rent-Equipment & Vehicles	Beds	2,493	25	318,843		72	9,208	7
8	36	Other	Beds	2,493	25			72		8
9	38	Medically Nec Transportation	Beds	2,493	25			72		9
10	39	Ancillary Service Centers	Beds	2,493	25	4,685		72	135	10
11	40	Barber and Beauty Shops	Beds	2,493	25			72		11
12	41	Coffee and Gift Shops	Beds	2,493	25			72		12
13	42	Other	Beds	2,493	25			72		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	\$		\$ 33,336	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			\$					\$ 24,450	1
2	Busey Bank		xx	Loan Fee Amortization								1,471	2
3													3
4													4
5													5
	Working Capital												
6	Busey Bank		xx	Working Capital								23,807	6
7													7
8													8
9	TOTAL Facility Related						\$					\$ 49,728	9
	B. Non-Facility Related*												
10	Interest Income											(491)	10
11													11
12	Allocated Corporate											1,896	12
13													13
14	TOTAL Non-Facility Related						\$					\$ 1,405	14
15	TOTALS (line 9+line14)						\$		\$			\$ 51,133	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.)		\$	32,506	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	32,506	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.		\$	32,506	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2015	31,149	8		
	2016	31,892	9		
	2017	32,082	10		
	2018	32,266	11		
	2019	32,506	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 Minonk COUNTY Woodford

FACILITY IDPH LICENSE NUMBER 0048058

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:

32,960

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			1997	\$ 25,000	1
2					2
3	TOTALS			\$ 25,000	3

Facility Name & ID Number Heritage Health Minonk

0048058

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	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	72		1997		\$ 898,709	\$		\$		4
5					141,199					5
6										6
7										7
8										8
	Improvement Type**									
9	1996 Improvements			1996	199,013					9
10	1997 Improvements			1997	(107,453)					10
11	1998 Improvements			1998	22,928					11
12	1999 Improvements			1999	16,328					12
13	2000 Improvements			2000	9,183					13
14	2001 Improvements			2001	3,366					14
15	2002 Improvements			2002	21,999					15
16	2003 Improvements			2003	34,768					16
17	2004 Improvements			2004	19,520					17
18	2005 Improvements			2005	15,675					18
19	2006 Improvements			2006	22,858					19
20	2007 Improvements			2007	66,306					20
21	2008 Improvements			2008	190,181					21
22	2009 Improvements			2009	63,136					22
23	2010 Improvements			2010	65,698					23
24	2011 Improvements			2011	619,556					24
25	2012 Improvements			2012	331,782					25
26	2013 Improvements			2013	140,112					26
27	2014 Improvements			2014	36,789					27
28										28
29	Install electronic security - (6) doors			2015	37,697					29
30	Replace fire sprinkler system			2015	180,553					30
31	Install new water heater; disconnect and remove old heater			2015	6,398					31
32										32
33										33
34	C/O Allocation					16,895		16,895		34
35	Book Depreciation					150,277		150,277		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 Minonk

0048058

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	5,088						38
39								39
40	2017	3,273						40
41	2017	6,185						41
42								42
43	2018							43
44								44
45	2019	3,900						45
46	2019	8,375						46
47								47
48	2020	116,192						48
49	2020	7,200						49
50								50
51	2020	41,879						51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70		\$ 3,228,393	\$ 167,172		\$ 167,172	\$	\$	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	\$613,087	\$14,410	\$14,410	\$		\$	71
72	Current Year Purchases	86,244						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$699,331	\$14,410	\$14,410	\$		\$	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	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$60,815	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$4,013,539	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$181,582	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$181,582	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☐ NOTerms:*

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:\$41,928Description: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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 224,085	\$		\$ 224,085	1
2	Licensed Speech and Language Development Therapist		hrs			24,804			24,804	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			197,701	255		197,956	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				132,127		132,127	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					38,688			38,688	13
14	TOTAL			\$		\$ 485,278	\$ 132,382		\$ 617,660	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	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 4,869	\$	1
2	Cash-Patient Deposits	6,134		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	24,141		3
4	Supply Inventory (priced at FIFO)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,391,043)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (1,355,899)	\$	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)	\$ (1,355,899)	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,134		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	120,744		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,492		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	4,261		36
37	Deferred Stimulus	135,301		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 277,932	\$	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)	\$ 277,932	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,633,831)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (1,355,899)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,521,707)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,521,707)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(112,124)	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)	\$ (112,124)	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)	\$ (1,633,831)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Health Minonk

0048058

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	\$ 3,363,373	1
2	Discounts and Allowances for all Levels	(1,272,633)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,090,740	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,334,236	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,334,236	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	257,122	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	635	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	236,122	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	5,917	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 499,796	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	491	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 491	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)	\$ 3,925,263	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	704,367	31
32	Health Care	1,617,136	32
33	General Administration	888,199	33
	B. Capital Expense		
34	Ownership	381,095	34
	C. Ancillary Expense		
35	Special Cost Centers	446,590	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,037,387	40
41	Income before Income Taxes (line 30 minus line 40)**	(112,124)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (112,124)	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	2,044	2,129	\$ 79,351	\$ 37.27	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,393	6,660	230,392	34.59	3
4	Licensed Practical Nurses	9,913	10,326	308,161	29.84	4
5	CNAs & Orderlies	30,789	32,072	498,633	15.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,438	3,581	80,406	22.45	8
9	Activity Director					9
10	Activity Assistants	4,609	4,802	63,828	13.29	10
11	Social Service Workers	2,093	2,181	47,875	21.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,248	15,883	184,985	11.65	15
16	Dishwashers					16
17	Maintenance Workers	4,913	5,118	65,723	12.84	17
18	Housekeepers	4,597	4,789	50,464	10.54	18
19	Laundry	3,825	3,985	40,956	10.28	19
20	Administrator	2,069	2,155	81,447	37.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,136	4,308	136,866	31.77	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)					33
34	TOTAL (lines 1 - 33)	94,067	97,989	\$ 1,869,087 *	\$ 19.07	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		\$ 4,685	L1 C3	35
36	Medical Director		7,150	L9 C3	36
37	Medical Records Consultant		535	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,521	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		1,657	L12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 17,548		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 13,404	L10 C3	50
51	Licensed Practical Nurses		1,302	L10 C3	51
52	Certified Nurse Assistants/Aides		21,072	L10 C3	52
53	TOTAL (lines 50 - 52)		\$ 35,778		53

Facility Name & ID Number		Heritage Health Minonk		STATE OF ILLINOIS		# 0048058		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					
Amy Rozanski		Administrator				\$ 81,447		Workers' Compensation Insurance		\$ 9,495		IDPH License Fee		\$					
								Unemployment Compensation Insurance		4,469		Advertising: Employee Recruitment		1,664					
								FICA Taxes		142,985		Health Care Worker Background Check							
								Employee Health Insurance		93,361		(Indicate # of checks performed)		1,025					
								Employee Meals				Patient Background Checks							
								Illinois Municipal Retirement Fund (IMRF)*											
												PR		7,130					
TOTAL (agree to Schedule V, line 17, col. 1)								Other Benefits		53,521		Dues & Subscriptions		5,557					
(List each licensed administrator separately.)						\$ 81,447		Central Office Allocation		30,182		License & Fees		4,991					
B. Administrative - Other												Central Office Allocation				692			
Description						Amount						Less: Public Relations Expense		(7,130)					
						\$						Non-allowable advertising		(3,037)					
												Yellow page advertising		()					
TOTAL (agree to Schedule V, line 17, col. 3)						\$		TOTAL (agree to Schedule V, line 22, col.8)		\$ 334,013		TOTAL (agree to Sch. V, line 20, col. 8)		\$ 10,892					
(Attach a copy of any management service agreement)																			
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**											
Vendor/Payee		Type				Amount		Description		Line #		Amount		Description		Amount			
Heritage Operations Group		Management				\$ 195,980						\$		Out-of-State Travel		\$			
Legal adj to Zero						6,164													
TOTAL (agree to Schedule V, line 19, column 3)						\$ 202,144		TOTAL		\$				Entertainment Expense		()			
(For legal fee disclosure, see page 39 of instructions)																(agree to Sch. V, line 24, col. 8)		TOTAL 4,999	
								* Attach copy of IMRF notifications								**See instructions.			

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI - \$5,040

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 Yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? YES xx NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO xx If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 88,839
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 836

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

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

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

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

Heritage Manor - Minonk
IDPH ID# 48058
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	\$ 132,127
Purchased Hospital Services	7,406
Purchased Laboratory Services	29,395
Purchased Radiology Services	1,887
Amount Reclassified to Line 39	\$ <u>170,815</u>

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

<u>Line Item</u>	
Provider Participation Fee - \$1.50	\$ (26,901)
Provider Assesment Fee - \$6.07	<u>(61,938)</u>
	\$ <u>(88,839)</u>
Provider Participation Fee	\$ <u>88,839</u>

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

<u>Line Item</u>	
Pharmacy Consulting Fees	\$ <u>3,521</u>