

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0048074</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Heritage Health Mt Zion</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>1225 Woodland Drive</u> <u>Mt Zion</u> <u>62549</u>																									
Number City Zip Code																									
County: <u>Macon</u>																									
Telephone Number: <u>217 864-2356</u> Fax # ()																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>David M Underwood</u></td></tr><tr><td>(Title) <u>EVP & CFO</u></td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) () Fax # ()</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>David M Underwood</u>	(Title) <u>EVP & CFO</u>	(Date) _____	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) () Fax # ()											
Officer or Administrator of Provider	(Signed) _____																								
	(Type or Print Name) <u>David M Underwood</u>																								
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	(Date) _____																								
Paid Preparer	(Signed) _____																								
	(Date) _____																								
	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
	(Telephone) () Fax # ()																								
Date of Initial License for Current Owners: <u>July 2007</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
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	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>David M Underwood</u> Telephone Number: <u>(309)8237135</u>																									
Email Address: _____																									

Facility Name & ID Number Heritage Health Mt Zion

0048074 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 3-13-2020

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	75	Skilled (SNF)		71	26,274		1
2		Skilled Pediatric (SNF/PED)					2
3		Intermediate (ICF)					3
4		Intermediate/DD					4
5		Sheltered Care (SC)					5
6		ICF/DD 16 or Less					6
7	75	TOTALS		71	26,274		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	14,072	4,193	2,912	21,177	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,072	4,193	2,912	21,177	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 80.60%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 71 and days of care provided 2,912

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

Facility Name & ID Number Heritage Health Mt Zion # 0048074 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	182,073	16,910	5,499	204,482		204,482	3,464	207,946			1
2	Food Purchase		149,089		149,089		149,089	(12)	149,077			2
3	Housekeeping	86,314	25,529		111,843		111,843	4,618	116,461			3
4	Laundry	99,356	9,331		108,687		108,687	330	109,017			4
5	Heat and Other Utilities			100,011	100,011		100,011	1,099	101,110			5
6	Maintenance	62,500	47,967	84,066	194,533		194,533	13,478	208,011			6
7	Other (specify):*											7
8	TOTAL General Services	430,243	248,826	189,576	868,645		868,645	22,977	891,622			8
	B. Health Care and Programs											
9	Medical Director			22,797	22,797		22,797		22,797			9
10	Nursing and Medical Records	1,463,089	120,795	587,924	2,171,808	(4,620)	2,167,188	6,187	2,173,375			10
10a	Therapy		147,669	1,603	149,272	(144,213)	5,059		5,059			10a
11	Activities	83,698	243		83,941		83,941	4	83,945			11
12	Social Services	29,951		5,037	34,988		34,988	99	35,087			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,576,738	268,707	617,361	2,462,806	(148,833)	2,313,973	6,290	2,320,263			16
	C. General Administration											
17	Administrative	102,707			102,707		102,707		102,707			17
18	Directors Fees											18
19	Professional Services			296,880	296,880		296,880	(282,368)	14,512			19
20	Dues, Fees, Subscriptions & Promotions			173,078	173,078	(153,381)	19,697	(6,041)	13,656			20
21	Clerical & General Office Expenses	210,621	26,889	7,685	245,195		245,195	295,546	540,741			21
22	Employee Benefits & Payroll Taxes			416,712	416,712		416,712	29,763	446,475			22
23	Inservice Training & Education			368	368		368	792	1,160			23
24	Travel and Seminar			2,964	2,964		2,964	2,035	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			43,245	43,245		43,245	49,306	92,551			26
27	Other (specify):* Lost resident items			56	56		56	782	838			27
28	TOTAL General Administration	313,328	26,889	940,988	1,281,205	(153,381)	1,127,824	89,815	1,217,639			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,320,309	544,422	1,747,925	4,612,656	(302,214)	4,310,442	119,082	4,429,524			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							98,964	98,964			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			36,440	36,440		36,440	51,019	87,459			32
33	Real Estate Taxes							70,105	70,105			33
34	Rent-Facility & Grounds			328,500	328,500		328,500	(323,371)	5,129			34
35	Rent-Equipment & Vehicles			39,459	39,459		39,459	9,081	48,540			35
36	Other (specify):*											36
37	TOTAL Ownership			404,399	404,399		404,399	(94,202)	310,197			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			577,968	577,968	148,833	726,801	158,953	885,754			39
40	Barber and Beauty Shops			1,737	1,737		1,737		1,737			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					153,381	153,381		153,381			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			579,705	579,705	302,214	881,919	158,953	1,040,872			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,320,309	544,422	2,732,029	5,596,760		5,596,760	183,833	5,780,593			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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(1,398)			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	(3,265)			17
18	Fines and Penalties				18
19	Entertainment	(1,661)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(15,959)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	782			24
25	Fund Raising, Advertising and Promotional	(3,458)			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)	\$ (24,959)		\$	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	2	
		Amount	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)	208,792		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 208,792		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 183,833		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	2	3	4	
		Yes	No	Amount	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		(15,959)	19	11
12		(1,398)	32	12
13		782	27	13
14		(3,458)	20	14
15		(3,265)	20	15
16		0	27	16
17		(1,661)	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	(24,959)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Mt Zion# 0048074

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	3,464	0	0	0	0	0	0	0	0	3,464	1
2	Food Purchase	0	0	(12)	0	0	0	0	0	0	0	0	(12)	2
3	Housekeeping	0	0	4,618	0	0	0	0	0	0	0	0	4,618	3
4	Laundry	0	0	330	0	0	0	0	0	0	0	0	330	4
5	Heat and Other Utilities	0	0	1,099	0	0	0	0	0	0	0	0	1,099	5
6	Maintenance	0	0	13,478	0	0	0	0	0	0	0	0	13,478	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	22,977	0	0	0	0	0	0	0	0	22,977	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	(11,752)	17,939	0	0	0	0	0	0	0	0	6,187	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	99	0	0	0	0	0	0	0	0	99	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	(11,752)	18,042	0	0	0	0	0	0	0	0	6,290	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	(15,959)	(278,167)	11,758	0	0	0	0	0	0	0	0	(282,368)	19
20	Fees, Subscriptions & Promotions	(6,723)	0	682	0	0	0	0	0	0	0	0	(6,041)	20
21	Clerical & General Office Expenses	0	0	295,546	0	0	0	0	0	0	0	0	295,546	21
22	Employee Benefits & Payroll Taxes	0	0	29,763	0	0	0	0	0	0	0	0	29,763	22
23	Inservice Training & Education	0	(144)	936	0	0	0	0	0	0	0	0	792	23
24	Travel and Seminar	(1,661)	0	3,696	0	0	0	0	0	0	0	0	2,035	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	49,306	0	0	0	0	0	0	0	0	49,306	26
27	Other (specify):*	782	0	0	0	0	0	0	0	0	0	0	782	27
28	TOTAL General Administration	(23,561)	(278,311)	391,687	0	0	0	0	0	0	0	0	89,815	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(23,561)	(290,063)	432,706	0	0	0	0	0	0	0	0	119,082	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Mt Zion # 0048074 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	82,304	0	16,660	0	0	0	0	0	0	0	98,964	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,398)	50,547	0	1,870	0	0	0	0	0	0	0	51,019	32
33	Real Estate Taxes	0	70,105	0	0	0	0	0	0	0	0	0	70,105	33
34	Rent-Facility & Grounds	0	(328,500)	0	5,129	0	0	0	0	0	0	0	(323,371)	34
35	Rent-Equipment & Vehicles	0	0	0	9,081	0	0	0	0	0	0	0	9,081	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,398)	(125,544)	0	32,740	0	0	0	0	0	0	0	(94,202)	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	158,820	0	133	0	0	0	0	0	0	0	158,953	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	158,820	0	133	0	0	0	0	0	0	0	158,953	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(24,959)	(256,787)	432,706	32,873	0	0	0	0	0	0	0	183,833	45

VII. RELATED PARTIES

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

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

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Adjustment for Related Organiza	\$	GreenTree Pharmacy		\$ (11,752)	\$ (11,752)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy		(144)	(144)	2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy		158,820	158,820	3
4	V	19	Adjustment for Related Organization	278,167	Heritage Operations Group, LLC			(278,167)	4
5	V								5
6	V	34	Adjustment for Related Organization	328,500	Heritage Manor Real Estate, LLC			(328,500)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		70,105	70,105	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		47,678	47,678	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		82,304	82,304	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		2,869	2,869	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 606,667			\$ 349,880	\$ * (256,787)	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		\$ 3,464	\$ 3,464	15
16	V	2	Food Purchase		Heritage Operations Group		(12)	(12)	16
17	V	3	Housekeeping		Heritage Operations Group		4,618	4,618	17
18	V	4	Laundry		Heritage Operations Group		330	330	18
19	V	5	Heat & Other Utilities		Heritage Operations Group		1,099	1,099	19
20	V	6	Maintenance		Heritage Operations Group		13,478	13,478	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		17,939	17,939	23
24	V	11	Activities		Heritage Operations Group		4	4	24
25	V	12	Social Service		Heritage Operations Group		99	99	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		11,758	11,758	31
32	V	20	Fees, Subscription, Promotions		Heritage Operations Group		682	682	32
33	V	21	Clerical & General Office Expenses		Heritage Operations Group		295,546	295,546	33
34	V	22	Employee Benefits & Payroll Taxes		Heritage Operations Group		29,763	29,763	34
35	V	23	Inservice Training & Education		Heritage Operations Group		936	936	35
36	V	24	Travel and Seminar		Heritage Operations Group		3,696	3,696	36
37	V	25	Other Admin. Staff Transportation		Heritage Operations Group		0		37
38	V	26	Insurance-Prop.Liab.Malpract		Heritage Operations Group		49,306	49,306	38
39	Total			\$			\$ 432,706	\$ * 432,706	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	Other	\$	Heritage Operations Group		\$ 0	\$	15
16	V	30	Depreciation		Heritage Operations Group		16,660	16,660	16
17	V	31	Amortization of Pre-Op & Org		Heritage Operations Group		0		17
18	V	32	Interest		Heritage Operations Group		1,870	1,870	18
19	V	33	Real Estate Taxes		Heritage Operations Group		0		19
20	V	34	Rent-Facility & Grounds		Heritage Operations Group		5,129	5,129	20
21	V	35	Rent-Equipment & Vehicles		Heritage Operations Group		9,081	9,081	21
22	V	36	Other		Heritage Operations Group		0		22
23	V	38	Medically Nec Transportation		Heritage Operations Group		0		23
24	V	39	Ancillary Service Centers		Heritage Operations Group		133	133	24
25	V	40	Barber and Beauty Shops		Heritage Operations Group		0		25
26	V	41	Coffee and Gift Shops		Heritage Operations Group		0		26
27	V	42	Other		Heritage Operations Group		0		27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 32,873	\$ * 32,873	39

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

Facility Name & ID Number Heritage Health Mt Zion # 0048074 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Main SNF Services LLC			100.00	0	0			\$ 0		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Heritage Health Mt Zion# 0048074

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	71	\$ 3,464	1
2	2	Food Purchase	Beds	2,493	25	(423)	0	71	(12)	2
3	3	Housekeeping	Beds	2,493	25	162,156	0	71	4,618	3
4	4	Laundry	Beds	2,493	25	11,591	0	71	330	4
5	5	Heat & Other Utilities	Beds	2,493	25	38,605	0	71	1,099	5
6	6	Maintenance	Beds	2,493	25	473,233	88,567	71	13,478	6
7	7	Other	Beds	2,493	25	0	0	71	0	7
8	9	Medical Director	Beds	2,493	25	0	0	71	0	8
9	10	Nursing & Medical Records	Beds	2,493	25	629,872	35,401	71	17,939	9
10	11	Activities	Beds	2,493	25	129	0	71	4	10
11	12	Social Service	Beds	2,493	25	3,478	3,478	71	99	11
12	13	Nurse Aide Training	Beds	2,493	25	0	0	71	0	12
13	14	Program Transportation	Beds	2,493	25	0	0	71	0	13
14	15	Other	Beds	2,493	25	0	0	71	0	14
15	17	Administrative	Beds	2,493	25	0	0	71	0	15
16	18	Directors Fees	Beds	2,493	25	0	0	71	0	16
17	19	Professional Services	Beds	2,493	25	412,869	0	71	11,758	17
18	20	Fees, Subscription, Promotions	Beds	2,493	25	23,945	0	71	682	18
19	21	Clerical & General Office Expense	Beds	2,493	25	10,377,428	9,978,005	71	295,546	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,493	25	1,045,059	0	71	29,763	20
21	23	Inservice Training & Education	Beds	2,493	25	32,865	0	71	936	21
22	24	Travel and Seminar	Beds	2,493	25	129,776	0	71	3,696	22
23	25	Other Admin. Staff Transportation	Beds	2,493	25	0	0	71	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,493	25	1,731,253	0	71	49,306	24
25	TOTALS					\$ 15,193,470	\$ 10,226,789		\$ 432,706	25

Facility Name & ID Number Heritage Health Mt Zion# 0048074

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	27	Other	Beds	2,493	25	\$	71	\$	1
2	30	Depreciation	Beds	2,493	25	584,981	71	16,660	2
3	31	Amortization of Pre-Op & Org	Beds	2,493	25		71		3
4	32	Interest	Beds	2,493	25	65,658	71	1,870	4
5	33	Real Estate Taxes	Beds	2,493	25		71		5
6	34	Rent-Facility & Grounds	Beds	2,493	25	180,106	71	5,129	6
7	35	Rent-Equipment & Vehicles	Beds	2,493	25	318,843	71	9,081	7
8	36	Other	Beds	2,493	25		71		8
9	38	Medically Nec Transportation	Beds	2,493	25		71		9
10	39	Ancillary Service Centers	Beds	2,493	25	4,685	71	133	10
11	40	Barber and Beauty Shops	Beds	2,493	25		71		11
12	41	Coffee and Gift Shops	Beds	2,493	25		71		12
13	42	Other	Beds	2,493	25		71		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	\$	\$ 32,873	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			\$				\$	47,678	1
2	Busey Bank		xx	Loan Fee Amortization								2,869	2
3													3
4													4
5													5
	Working Capital												
6	Busey Bank		xx	Working Capital								36,440	6
7													7
8													8
9	TOTAL Facility Related						\$				\$	86,987	9
	B. Non-Facility Related*												
10	Interest Income											(1,398)	10
11													11
12	Allocated Corporate											1,870	12
13													13
14	TOTAL Non-Facility Related						\$				\$	472	14
15	TOTALS (line 9+line14)						\$				\$	87,459	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.)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2019 report.		\$		1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	70,105	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	70,105	3	
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	70,105	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2015	64,686	8		
	2016	66,816	9		
	2017	67,362	10		
	2018	68,150	11		
	2019	70,105	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

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 Mt Zion COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0048074

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

PLEASE NOTE: *Payment information from the Internet* or otherwise is **not considered acceptable tax bill documentation** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

A. Square Feet: 21,920

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			Oct-98	\$ 50,000	1
2					2
3	TOTALS			\$ 50,000	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	71				\$ 1,076,000	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	1998 Improvements		1998		3,522					9
10	1999 Improvements		1999		22,404					10
11	2000 Improvements		2000		306,587					11
12	2001 Improvements		2001		1,457,045					12
13	2002 Improvements		2002		5,528					13
14	2003 Improvements		2003		5,300					14
15	2004 Improvements		2004		1,985					15
16	2005 Improvements		2005		2,968					16
17	2006 Improvements		2006		16,043					17
18	2007 Improvements		2007		35,615					18
19	2008 Improvements - None		2008							19
20	2009 Improvements		2009		106,936					20
21	2010 Improvements		2010		16,232					21
22	2011 Improvements		2011		224,220					22
23	2012 Improvements		2012		13,146					23
24	2013 Improvements		2013		6,060					24
25	2014 Improvements		2014		18,228					25
26										26
27	Schematic Design Fees - Facility Renovation Project		2015		2,101					27
28	Install (8) six gallon electric water heaters		2015		6,930					28
29	Replace compressor on walk-in freezer		2015		3,843					29
30										30
31										31
32										32
33										33
34	C/O Allocation					16,660		16,660		34
35	Book Depreciation					68,926		68,926		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 Mt Zion

0048074

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	No Improvements made in 2016	2016						38
39								39
40	Removed and replaced heat exchangers in both north and south wings	2017	10,601					40
41								41
42								42
43	Installed split heating/cooling system - Laundry Room	2018	6,490					43
44	Air unit replacement - 100 Wing	2018	40,627					44
45	Air unit replacement - 200 Wing	2018	45,627					45
46								46
47	Repair floor drains	2019	4,808					47
48	Replace heat exchanger	2019	4,190					48
49								49
50	Install new electric water heater	2020	8,735					50
51	Patch, seal and stripe parking lot	2020	3,939					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	TOTAL (lines 4 thru 69)		\$ 3,455,710	\$ 85,586		\$ 85,586	\$	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	\$779,404	\$13,378	\$13,378	\$		\$	71
72	Current Year Purchases	2,920						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$782,324	\$13,378	\$13,378	\$		\$	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	4,288,034
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	98,964
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	98,964
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:None
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
9. Option to Buy:

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$39,459Description:Televisions and Office equipment
(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	\$		\$ 267,565	\$		\$ 267,565	1
2	Licensed Speech and Language Development Therapist		hrs			45,225			45,225	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			265,178	439		265,617	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				147,230		147,230	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					1,603			1,603	13
14	TOTAL			\$		\$ 579,571	\$ 147,669		\$ 727,240	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	\$ 4,485	\$	1
2	Cash-Patient Deposits	46,936		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	353,856		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)	(139,568)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 265,709	\$	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)	\$ 265,709	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	46,936		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	175,598		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,974		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	9,469		36
37	Deferred Stimulus	139,865		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 373,842	\$	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)	\$ 373,842	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (108,133)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 265,709	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (189,302)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (189,302)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	81,169	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)	\$ 81,169	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)	\$ (108,133)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Health Mt Zion

0048074

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,828,964	1
2	Discounts and Allowances for all Levels	(1,640,872)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,188,092	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,820,005	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,820,005	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	408,024	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,739	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	256,572	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	709	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 667,044	23
	D. Non-Operating Revenue		
24	Contributions	1,390	24
25	Interest and Other Investment Income***	1,398	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,788	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,677,929	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	868,645	31
32	Health Care	2,462,806	32
33	General Administration	1,281,205	33
	B. Capital Expense		
34	Ownership	404,399	34
	C. Ancillary Expense		
35	Special Cost Centers	579,705	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,596,760	40
41	Income before Income Taxes (line 30 minus line 40)**	81,169	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 81,169	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	1,615	1,682	\$ 79,600	\$ 47.32	1
2	Assistant Director of Nursing	1,355	1,411	51,773	36.69	2
3	Registered Nurses	9,654	10,057	352,811	35.08	3
4	Licensed Practical Nurses	9,784	10,192	287,725	28.23	4
5	CNAs & Orderlies	38,812	40,429	615,036	15.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,285	2,380	76,144	31.99	8
9	Activity Director					9
10	Activity Assistants	5,188	5,404	83,698	15.49	10
11	Social Service Workers	1,875	1,954	29,951	15.33	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,320	14,916	182,073	12.21	15
16	Dishwashers					16
17	Maintenance Workers	2,509	2,614	62,500	23.91	17
18	Housekeepers	7,547	7,861	86,314	10.98	18
19	Laundry	6,294	6,556	99,356	15.15	19
20	Administrator	2,071	2,157	102,707	47.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,140	8,479	210,621	24.84	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)	111,449	116,092	\$ 2,320,309 *	\$ 19.99	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		\$ 5,499	L1 C3	35
36	Medical Director		22,797	L9 C3	36
37	Medical Records Consultant		896	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,620	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		4,942	L12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 38,754		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 109,270	L10 C3	50
51	Licensed Practical Nurses		130,793	L10 C3	51
52	Certified Nurse Assistants/Aides		342,345	L10 C3	52
53	TOTAL (lines 50 - 52)		\$ 582,408		53

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 - \$5,250</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>153,381</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>721</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> |
|---|---|

HFS 3745 (9-4-00)

Heritage Manor - Mt. Zion
IDPH ID# 48074
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	\$ 147,230
Purchased Hospital Services	1,178
Purchased Laboratory Services	300
Purchased Radiology Services	125
Amount Reclassified to Line 39	\$ <u>148,833</u>

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

<u>Line Item</u>	
Provider Participation Fee - \$1.50	\$ (39,411)
Provider Assesment Fee - \$6.07	<u>(113,970)</u>
	\$ <u>(153,381)</u>
 Provider Participation Fee	 \$ <u>153,381</u>

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

<u>Line Item</u>	
Pharmacy Consulting Fees	\$ <u>4,620</u>