

		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: 0048082

Facility Name: Heritage Health Normal

Address: 509 N Adelaide Normal 61761
Number City Zip Code

County: McLean

Telephone Number: (309) 452-7468 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: July 2006

Type of Ownership:

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

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

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or
Administrator
of Provider

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

Paid
Preparer

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

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

Facility Name & ID Number Heritage Health Normal

0048082 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>141</u>	Skilled (SNF)	<u>141</u>	<u>51,606</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>141</u>	TOTALS	<u>141</u>	<u>51,606</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>22,013</u>	<u>16,144</u>	<u>2,078</u>	<u>40,235</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>22,013</u>	<u>16,144</u>	<u>2,078</u>	<u>40,235</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.97%

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 141 and days of care provided 2,078

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 Normal # 0048082 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	537,466	49,365	7,920	594,751		594,751	6,879	601,630			1
2	Food Purchase		314,291		314,291		314,291	(24)	314,267			2
3	Housekeeping	264,143	46,923		311,066		311,066	9,171	320,237			3
4	Laundry	102,924	26,429		129,353		129,353	656	130,009			4
5	Heat and Other Utilities			121,886	121,886		121,886	2,183	124,069			5
6	Maintenance	109,075	73,123	187,703	369,901		369,901	26,765	396,666			6
7	Other (specify):*											7
8	TOTAL General Services	1,013,608	510,131	317,509	1,841,248		1,841,248	45,630	1,886,878			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	3,592,154	265,735	1,046,102	4,903,991	(9,149)	4,894,842	11,052	4,905,894			10
10a	Therapy		261,528	38,391	299,919	(290,190)	9,729		9,729			10a
11	Activities	127,489	6,039		133,528		133,528	7	133,535			11
12	Social Services	127,860		2,594	130,454		130,454	197	130,651			12
13	CNA Training	6,695	5,538		12,233		12,233		12,233			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,854,198	538,840	1,101,487	5,494,525	(299,339)	5,195,186	11,256	5,206,442			16
	C. General Administration											
17	Administrative	94,157			94,157		94,157		94,157			17
18	Directors Fees											18
19	Professional Services			545,367	545,367		545,367	(516,830)	28,537			19
20	Dues, Fees, Subscriptions & Promotions			375,545	375,545	(318,315)	57,230	(21,855)	35,375			20
21	Clerical & General Office Expenses	518,898	38,575	14,324	571,797		571,797	586,930	1,158,727			21
22	Employee Benefits & Payroll Taxes			1,068,165	1,068,165		1,068,165	59,107	1,127,272			22
23	Inservice Training & Education			195	195		195	1,787	1,982			23
24	Travel and Seminar			4,756	4,756		4,756	243	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			82,563	82,563		82,563	97,917	180,480			26
27	Other (specify):*			120,968	120,968		120,968	(120,968)				27
28	TOTAL General Administration	613,055	38,575	2,211,883	2,863,513	(318,315)	2,545,198	86,331	2,631,529			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,480,861	1,087,546	3,630,879	10,199,286	(617,654)	9,581,632	143,217	9,724,849			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							509,746	509,746			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			69,993	69,993		69,993	120,711	190,704			32
33	Real Estate Taxes							113,147	113,147			33
34	Rent-Facility & Grounds			718,320	718,320		718,320	(708,133)	10,187			34
35	Rent-Equipment & Vehicles			84,154	84,154		84,154	18,033	102,187			35
36	Other (specify):*											36
37	TOTAL Ownership			872,467	872,467		872,467	53,504	925,971			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			662,096	662,096	299,339	961,435	410,285	1,371,720			39
40	Barber and Beauty Shops		96	6,025	6,121		6,121		6,121			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					318,315	318,315		318,315			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		96	668,121	668,217	617,654	1,285,871	410,285	1,696,156			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,480,861	1,087,642	5,171,467	11,739,970		11,739,970	607,006	12,346,976			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	(810)			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	(6,906)			17
18	Fines and Penalties	(875)			18
19	Entertainment	(7,097)			19
20	Contributions	(10)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(21,688)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(120,083)			24
25	Fund Raising, Advertising and Promotional	(16,303)			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)	\$ (173,772)		\$	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)	780,778		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 780,778		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 607,006		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		(21,688)	19	11
12		(810)	32	12
13		(120,083)	27	13
14		(16,303)	20	14
15		(10)	27	15
16		(875)	27	16
17		(7,097)	24	17
18		(6,906)	20	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	(173,772)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Normal# 0048082

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	6,879	0	0	0	0	0	0	0	0	6,879	1
2	Food Purchase	0	0	(24)	0	0	0	0	0	0	0	0	(24)	2
3	Housekeeping	0	0	9,171	0	0	0	0	0	0	0	0	9,171	3
4	Laundry	0	0	656	0	0	0	0	0	0	0	0	656	4
5	Heat and Other Utilities	0	0	2,183	0	0	0	0	0	0	0	0	2,183	5
6	Maintenance	0	0	26,765	0	0	0	0	0	0	0	0	26,765	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	45,630	0	0	0	0	0	0	0	0	45,630	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	(24,573)	35,625	0	0	0	0	0	0	0	0	11,052	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	7	0	0	0	0	0	0	0	0	7	11
12	Social Services	0	0	197	0	0	0	0	0	0	0	0	197	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	(24,573)	35,829	0	0	0	0	0	0	0	0	11,256	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	(21,688)	(518,493)	23,351	0	0	0	0	0	0	0	0	(516,830)	19
20	Fees, Subscriptions & Promotions	(23,209)	0	1,354	0	0	0	0	0	0	0	0	(21,855)	20
21	Clerical & General Office Expenses	0	0	586,930	0	0	0	0	0	0	0	0	586,930	21
22	Employee Benefits & Payroll Taxes	0	0	59,107	0	0	0	0	0	0	0	0	59,107	22
23	Inservice Training & Education	0	(72)	1,859	0	0	0	0	0	0	0	0	1,787	23
24	Travel and Seminar	(7,097)	0	7,340	0	0	0	0	0	0	0	0	243	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	97,917	0	0	0	0	0	0	0	0	97,917	26
27	Other (specify):*	(120,968)	0	0	0	0	0	0	0	0	0	0	(120,968)	27
28	TOTAL General Administration	(172,962)	(518,565)	777,858	0	0	0	0	0	0	0	0	86,331	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(172,962)	(543,138)	859,317	0	0	0	0	0	0	0	0	143,217	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Normal # 0048082 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	476,660	0	33,086	0	0	0	0	0	0	0	509,746	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(810)	117,807	0	3,714	0	0	0	0	0	0	0	120,711	32
33	Real Estate Taxes	0	113,147	0	0	0	0	0	0	0	0	0	113,147	33
34	Rent-Facility & Grounds	0	(718,320)	0	10,187	0	0	0	0	0	0	0	(708,133)	34
35	Rent-Equipment & Vehicles	0	0	0	18,033	0	0	0	0	0	0	0	18,033	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(810)	(10,706)	0	65,020	0	0	0	0	0	0	0	53,504	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	410,020	0	265	0	0	0	0	0	0	0	410,285	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	410,020	0	265	0	0	0	0	0	0	0	410,285	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(173,772)	(143,824)	859,317	65,285	0	0	0	0	0	0	0	607,006	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		\$ (24,573)	\$ (24,573)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy		(72)	(72)	2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy		410,020	410,020	3
4	V	19	Adjustment for Related Organization	518,493	Heritage Operations Group, LLC			(518,493)	4
5	V								5
6	V	34	Adjustment for Related Organization	718,320	Heritage Manor Real Estate, LLC			(718,320)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		113,147	113,147	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		110,004	110,004	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		476,660	476,660	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		7,803	7,803	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,236,813			\$ 1,092,989	\$ * (143,824)	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		\$ 6,879	\$ 6,879	15
16	V	2	Food Purchase		Heritage Operations Group		(24)	(24)	16
17	V	3	Housekeeping		Heritage Operations Group		9,171	9,171	17
18	V	4	Laundry		Heritage Operations Group		656	656	18
19	V	5	Heat & Other Utilities		Heritage Operations Group		2,183	2,183	19
20	V	6	Maintenance		Heritage Operations Group		26,765	26,765	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		35,625	35,625	23
24	V	11	Activities		Heritage Operations Group		7	7	24
25	V	12	Social Service		Heritage Operations Group		197	197	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		23,351	23,351	31
32	V	20	Fees, Subscription, Promotions		Heritage Operations Group		1,354	1,354	32
33	V	21	Clerical & General Office Expenses		Heritage Operations Group		586,930	586,930	33
34	V	22	Employee Benefits & Payroll Taxes		Heritage Operations Group		59,107	59,107	34
35	V	23	Inservice Training & Education		Heritage Operations Group		1,859	1,859	35
36	V	24	Travel and Seminar		Heritage Operations Group		7,340	7,340	36
37	V	25	Other Admin. Staff Transportation		Heritage Operations Group		0		37
38	V	26	Insurance-Prop.Liab.Malpract		Heritage Operations Group		97,917	97,917	38
39	Total			\$			\$ 859,317	\$ * 859,317	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			33,086	16
17	V	31			Heritage Operations Group			0	17
18	V	32			Heritage Operations Group			3,714	18
19	V	33			Heritage Operations Group			0	19
20	V	34			Heritage Operations Group			10,187	20
21	V	35			Heritage Operations Group			18,033	21
22	V	36			Heritage Operations Group			0	22
23	V	38			Heritage Operations Group			0	23
24	V	39			Heritage Operations Group			265	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			\$			\$ 0	\$ * 65,285	39

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

Facility Name & ID Number Heritage Health Normal # 0048082 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 Normal# 0048082

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	141	\$ 6,879	1
2	2	Food Purchase	Beds	2,493	25	(423)	0	141	(24)	2
3	3	Housekeeping	Beds	2,493	25	162,156	0	141	9,171	3
4	4	Laundry	Beds	2,493	25	11,591	0	141	656	4
5	5	Heat & Other Utilities	Beds	2,493	25	38,605	0	141	2,183	5
6	6	Maintenance	Beds	2,493	25	473,233	88,567	141	26,765	6
7	7	Other	Beds	2,493	25	0	0	141	0	7
8	9	Medical Director	Beds	2,493	25	0	0	141	0	8
9	10	Nursing & Medical Records	Beds	2,493	25	629,872	35,401	141	35,625	9
10	11	Activities	Beds	2,493	25	129	0	141	7	10
11	12	Social Service	Beds	2,493	25	3,478	3,478	141	197	11
12	13	Nurse Aide Training	Beds	2,493	25	0	0	141	0	12
13	14	Program Transportation	Beds	2,493	25	0	0	141	0	13
14	15	Other	Beds	2,493	25	0	0	141	0	14
15	17	Administrative	Beds	2,493	25	0	0	141	0	15
16	18	Directors Fees	Beds	2,493	25	0	0	141	0	16
17	19	Professional Services	Beds	2,493	25	412,869	0	141	23,351	17
18	20	Fees, Subscription, Promotions	Beds	2,493	25	23,945	0	141	1,354	18
19	21	Clerical & General Office Expense	Beds	2,493	25	10,377,428	9,978,005	141	586,930	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,493	25	1,045,059	0	141	59,107	20
21	23	Inservice Training & Education	Beds	2,493	25	32,865	0	141	1,859	21
22	24	Travel and Seminar	Beds	2,493	25	129,776	0	141	7,340	22
23	25	Other Admin. Staff Transportation	Beds	2,493	25	0	0	141	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,493	25	1,731,253	0	141	97,917	24
25	TOTALS					\$ 15,193,470	\$ 10,226,789		\$ 859,317	25

Facility Name & ID Number Heritage Health Normal# 0048082

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	\$	141	\$	1
2	30	Depreciation	Beds	2,493	25	584,981	141	33,086	2
3	31	Amortization of Pre-Op & Org	Beds	2,493	25		141		3
4	32	Interest	Beds	2,493	25	65,658	141	3,714	4
5	33	Real Estate Taxes	Beds	2,493	25		141		5
6	34	Rent-Facility & Grounds	Beds	2,493	25	180,106	141	10,187	6
7	35	Rent-Equipment & Vehicles	Beds	2,493	25	318,843	141	18,033	7
8	36	Other	Beds	2,493	25		141		8
9	38	Medically Nec Transportation	Beds	2,493	25		141		9
10	39	Ancillary Service Centers	Beds	2,493	25	4,685	141	265	10
11	40	Barber and Beauty Shops	Beds	2,493	25		141		11
12	41	Coffee and Gift Shops	Beds	2,493	25		141		12
13	42	Other	Beds	2,493	25		141		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	\$		\$ 65,285	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			\$					\$ 110,004	1
2	Busey Bank		xx	Loan Fee Amortization								7,803	2
3													3
4													4
5													5
	Working Capital												
6	Busey Bank		xx	Working Capital								69,993	6
7													7
8													8
9	TOTAL Facility Related						\$					\$ 187,800	9
	B. Non-Facility Related*												
10	Interest Income											(810)	10
11													11
12	Allocated Corporate											3,714	12
13													13
14	TOTAL Non-Facility Related						\$					\$ 2,904	14
15	TOTALS (line 9+line14)						\$					\$ 190,704	15

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$113,147	2
3. Under or (over) accrual (line 2 minus line 1).			\$113,147	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.			\$113,147	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2015	103,841	8	
	2016	106,738	9	
	2017	107,911	10	
	2018	111,900	11	
	2019	113,147	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 Normal COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0048082

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.

B. Real Estate Tax Cost Allocations

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.)

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

Page 10A

A. Square Feet: 51,164

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).
Adelaide Apts - Independent Living - No shared services but real estate taxes shown on same bill

E. Does this cost report reflect any organization or pre-operating costs which are being amortized?
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				\$ 181,333	1
2					2
3	TOTALS			\$ 181,333	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	141				\$ 1,860,193	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	1979 Improvements		1979		66,917					9
10	1980 Improvements		1980		48,089					10
11	1981 Improvements		1981		17,747					11
12	1982 Improvements		1982		18,009					12
13	1983 Improvements		1983		19,892					13
14	1984 Improvements		1984		25,484					14
15	1985 Improvements		1985		531,851					15
16	1986 Improvements		1986		82,460					16
17	1987 Improvements		1987		17,447					17
18	1988 Improvements		1988		133,532					18
19	1989 Improvements		1989		39,555					19
20	1990 Improvements		1990		18,557					20
21	1991 Improvements		1991		5,776					21
22	1991 Improvements		1992		8,016					22
23	1993 Improvements		1993		188,048					23
24	1994 Improvements		1994		187,325					24
25	1995 Improvements		1995		10,664					25
26	1996 Improvements		1996		39,518					26
27	1997 Improvements		1997		25,427					27
28	1998 Improvements		1998		1,932,921					28
29	1999 Improvements		1999		2,108,304					29
30	2000 Improvements		2000		81,048					30
31	2001 Improvements		2001		30,418					31
32	2002 Improvements		2002		42,330					32
33										33
34	C/O Allocation					33,086		33,086		34
35	Book Depreciation					380,017		380,017		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 Normal

0048082

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	2003 Improvements	2003	\$ 38,044	\$		\$	\$	\$	37
38	2004 Improvements	2004	50,416						38
39	2005 Improvements	2005	28,379						39
40	2006 Improvements	2006	5,900						40
41	2007 Improvements	2007	35,899						41
42	2008 Improvements	2008	186,351						42
43	2009 Improvements	2009	472,220						43
44	2010 Improvements	2010	118,174						44
45	2011 Improvements	2011	429,238						45
46	2012 Improvements	2012	217,692						46
47	2013 Improvements	2013	771,088						47
48	2014 Improvements	2014	366,084						48
49									49
50	Retube boiler	2015	15,200						50
51	New flooring - soiled utility room	2015	6,472						51
52	Compressor replacement	2015	3,861						52
53	Replacement split system for laundry room	2015	6,725						53
54	Replaced failed LCD annunciator	2015	3,910						54
55									55
56	Install new air compressor	2016	3,082						56
57	Upgrade elevator - installation of new alarms, lights	2016	10,330						57
58	pit ladder and phone								58
59	EIFS repairs to front car port and north side of building	2016	7,850						59
60									60
61	Replace old boiler	2017	252,610						61
62	Remove and replace stairwell flooring	2017	8,567						62
63	Added data lines for new offices and for point of care	2017	6,589						63
64	clinical system								64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 10,584,209	\$ 413,103		\$ 413,103	\$	\$	70

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

Facility Name & ID Number Heritage Health Normal

0048082

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 10,584,209	\$ 413,103		\$ 413,103	\$	\$	1
2									2
3	Replace water softener system	2018	8,379						3
4	Replace compressor - walk in cooler	2018	4,835						4
5	Replace roof top AC unit - East dining area	2018	14,665						5
6	New compressors - commons area	2018	5,401						6
7	Replace generator panel - RTU	2018	7,907						7
8	Replace hot water coil and air handler	2018	4,985						8
9									9
10	Remodeled (2) nurses stations - new cabinets, flooring,								10
11	and countertops; remediated asbestos; installed new electrical outl	2019	103,322						11
12	New cabling for wireless access locations	2019	8,958						12
13	Replace mixing valve	2019	2,925						13
14	Replace grease trap	2019	7,400						14
15	Install new fire hydrant	2019	3,500						15
16	Replace storm drain	2019	3,600						16
17	Replace air compressor - fire sprinkler system	2019	4,417						17
18	Install Bell & Gosset Pump - Legacy Unit	2019	3,125						18
19	Replace faulty hallway door	2019	2,593						19
20									20
21	Repair sprinkler system and adapt to new standards	2020	44,997						21
22	Install new 100 gallon water heater	2020	6,170						22
23	Replaced fire alarm system	2020	23,963						23
24	Replaced carpet - Legacy Unit	2020	14,230						24
25	Replaced HVAC-Main Hall Lounge	2020	7,615						25
26	Replaced Walk-In Freezer Door	2020	4,965						26
27	Replaced boiler system piping	2020	4,390						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,876,551	\$ 413,103		\$ 413,103	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$2,254,649	\$96,643	\$96,643	\$		\$	71
72	Current Year Purchases	46,042						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$2,300,691	\$96,643	\$96,643	\$		\$	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)			\$	13,358,575
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	509,746
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	509,746
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.☐ YES☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
9. Option to Buy:☐ YES☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental?☐ YES☐ NO
16. Rental Amount for movable equipment: \$84,154 Description: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		5,538		5,538
3	Classroom Wages (a)				
4	Clinical Wages (b)		6,695		6,695
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 12,233	\$	\$ 12,233
10	SUM OF line 9, col. 1 and 2 (e)	\$ 12,233			

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

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

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

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

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

\$
- D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	
- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 362,983	\$		\$ 362,983	1
2	Licensed Speech and Language Development Therapist		hrs			38,799			38,799	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			260,314	580		260,894	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				260,948		260,948	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					38,391			38,391	13
14	TOTAL			\$		\$ 700,487	\$ 261,528		\$ 962,015	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	\$ 400	\$	1
2	Cash-Patient Deposits	32,830		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	52,027		3
4	Supply Inventory (priced at FIFO)	18,784		4
5	Short-Term Investments			5
6	Prepaid Insurance	5,727		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,172,723)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (1,062,955)	\$	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)	\$ (1,062,955)	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,830		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	411,820		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,171		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	19,624		36
37	Deferred Stimulus	137,896		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 605,341	\$	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)	\$ 605,341	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,668,296)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (1,062,955)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (659,979)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (659,979)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,008,317)	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)	\$ (1,008,317)	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)	\$ (1,668,296)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Health Normal

0048082

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	\$ 9,715,095	1
2	Discounts and Allowances for all Levels	(1,753,470)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,961,625	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,703,020	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,703,020	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	694,570	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	7,096	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	365,236	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(704)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,066,198	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	810	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 810	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)	\$ 10,731,653	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,841,248	31
32	Health Care	5,494,525	32
33	General Administration	2,863,513	33
	B. Capital Expense		
34	Ownership	872,467	34
	C. Ancillary Expense		
35	Special Cost Centers	668,217	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)*	\$ 11,739,970	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,008,317)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,008,317)	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	987	1,029	\$ 56,544	\$ 54.95	1
2	Assistant Director of Nursing	3,430	3,573	109,112	30.54	2
3	Registered Nurses	15,007	15,632	613,564	39.25	3
4	Licensed Practical Nurses	32,762	34,127	1,049,172	30.74	4
5	CNAs & Orderlies	100,897	105,101	1,710,976	16.28	5
6	CNA Trainees	647	674	6,695	9.93	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,801	2,917	52,786	18.10	8
9	Activity Director					9
10	Activity Assistants	9,060	9,438	127,489	13.51	10
11	Social Service Workers	5,852	6,095	127,860	20.98	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	40,907	42,612	537,466	12.61	15
16	Dishwashers					16
17	Maintenance Workers	6,793	7,076	109,075	15.41	17
18	Housekeepers	22,376	23,309	264,143	11.33	18
19	Laundry	7,679	7,999	102,924	12.87	19
20	Administrator	2,020	2,104	94,157	44.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,813	21,681	518,898	23.93	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)	272,031	283,367	\$ 5,480,861 *	\$ 19.34	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		\$ 7,920	L1 C3	35
36	Medical Director		14,400	L9 C3	36
37	Medical Records Consultant		535	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		9,149	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		1,955	L12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 33,959		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 375,546	L10 C3	50
51	Licensed Practical Nurses		207,458	L10 C3	51
52	Certified Nurse Assistants/Aides		453,096	L10 C3	52
53	TOTAL (lines 50 - 52)		\$ 1,036,100		53

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI - \$9,872

(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. \$ 318,315
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. \$ 29,139

(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 - Normal
IDPH ID# 48157
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	\$ 260,948
Purchased Hospital Services	12,004
Purchased Laboratory Services	16,006
Purchased Radiology Services	10,381
Amount Reclassified to Line 39	\$ <u>299,339</u>

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

<u>Line Item</u>	
Provider Participation Fee - \$1.50	\$ (77,409)
Provider Assesment Fee - \$6.07	<u>(240,906)</u>
	\$ <u>(318,315)</u>
Provider Participation Fee	\$ <u>318,315</u>

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

<u>Line Item</u>	
Pharmacy Consulting Fees	\$ <u>9,149</u>