

		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: 0048090

Facility Name: Heritage Health Peru

Address: 1301 21st Street Peru 61354
Number City Zip Code

County: LaSalle

Telephone Number: (815) 223-4901 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 Peru

0048090 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>127</u>	Skilled (SNF)	<u>127</u>	<u>46,482</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>127</u>	TOTALS	<u>127</u>	<u>46,482</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>20,019</u>	<u>5,664</u>	<u>4,301</u>	<u>29,984</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>20,019</u>	<u>5,664</u>	<u>4,301</u>	<u>29,984</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.51%

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 127 and days of care provided 4,301

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL ☒ 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 Peru # 0048090 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	271,797	22,859	8,169	302,825		302,825	6,196	309,021			1
2	Food Purchase		272,396		272,396		272,396	(22)	272,374			2
3	Housekeeping	123,558	57,526		181,084		181,084	8,261	189,345			3
4	Laundry	40,481	9,485		49,966		49,966	590	50,556			4
5	Heat and Other Utilities			119,299	119,299		119,299	1,967	121,266			5
6	Maintenance	150,069	109,668	136,393	396,130		396,130	24,108	420,238			6
7	Other (specify):*											7
8	TOTAL General Services	585,905	471,934	263,861	1,321,700		1,321,700	41,100	1,362,800			8
	B. Health Care and Programs											
9	Medical Director			28,421	28,421		28,421		28,421			9
10	Nursing and Medical Records	3,061,357	232,360	14,368	3,308,085	(7,231)	3,300,854	6,384	3,307,238			10
10a	Therapy		287,587	136,511	424,098	(416,867)	7,231		7,231			10a
11	Activities	160,216	1,269		161,485		161,485	7	161,492			11
12	Social Services	70,604		1,845	72,449		72,449	177	72,626			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,292,177	521,216	181,145	3,994,538	(424,098)	3,570,440	6,568	3,577,008			16
	C. General Administration											
17	Administrative	101,194			101,194		101,194		101,194			17
18	Directors Fees											18
19	Professional Services			443,089	443,089		443,089	(417,245)	25,844			19
20	Dues, Fees, Subscriptions & Promotions			272,150	272,150	(231,847)	40,303	(27,682)	12,621			20
21	Clerical & General Office Expenses	327,268	30,981	8,718	366,967		366,967	528,654	895,621			21
22	Employee Benefits & Payroll Taxes			672,551	672,551		672,551	53,238	725,789			22
23	Inservice Training & Education			162	162		162	1,602	1,764			23
24	Travel and Seminar			5,075	5,075		5,075	(76)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			68,962	68,962		68,962	88,195	157,157			26
27	Other (specify):* Lost resident items			(11,129)	(11,129)		(11,129)	11,290	161			27
28	TOTAL General Administration	428,462	30,981	1,459,578	1,919,021	(231,847)	1,687,174	237,976	1,925,150			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,306,544	1,024,131	1,904,584	7,235,259	(655,945)	6,579,314	285,644	6,864,958			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							278,574	278,574			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			63,680	63,680		63,680	111,966	175,646			32
33	Real Estate Taxes							54,666	54,666			33
34	Rent-Facility & Grounds			568,451	568,451		568,451	(555,845)	12,606			34
35	Rent-Equipment & Vehicles			38,215	38,215		38,215	16,243	54,458			35
36	Other (specify):*											36
37	TOTAL Ownership			670,346	670,346		670,346	(94,396)	575,950			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			970,790	970,790	424,098	1,394,888	213,442	1,608,330			39
40	Barber and Beauty Shops			1,873	1,873		1,873		1,873			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					231,847	231,847		231,847			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			972,663	972,663	655,945	1,628,608	213,442	1,842,050			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,306,544	1,024,131	3,547,593	8,878,268		8,878,268	404,690	9,282,958			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	(4,762)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(6,162)			17
18	Fines and Penalties	(1,100)			18
19	Entertainment	(6,687)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(12,880)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	12,390			24
25	Fund Raising, Advertising and Promotional	(22,740)			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)	\$ (41,941)		\$	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)	446,631		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 446,631		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 404,690		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		(12,880)	19	11
12		(4,762)	32	12
13		12,390	27	13
14		(22,740)	20	14
15		(6,162)	20	15
16		(1,100)	27	16
17		(6,687)	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	(41,941)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Peru# 0048090

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	6,196	0	0	0	0	0	0	0	0	6,196	1
2	Food Purchase	0	0	(22)	0	0	0	0	0	0	0	0	(22)	2
3	Housekeeping	0	0	8,261	0	0	0	0	0	0	0	0	8,261	3
4	Laundry	0	0	590	0	0	0	0	0	0	0	0	590	4
5	Heat and Other Utilities	0	0	1,967	0	0	0	0	0	0	0	0	1,967	5
6	Maintenance	0	0	24,108	0	0	0	0	0	0	0	0	24,108	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	41,100	0	0	0	0	0	0	0	0	41,100	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	(25,703)	32,087	0	0	0	0	0	0	0	0	6,384	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	177	0	0	0	0	0	0	0	0	177	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	(25,703)	32,271	0	0	0	0	0	0	0	0	6,568	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	(12,880)	(425,398)	21,033	0	0	0	0	0	0	0	0	(417,245)	19
20	Fees, Subscriptions & Promotions	(28,902)	0	1,220	0	0	0	0	0	0	0	0	(27,682)	20
21	Clerical & General Office Expenses	0	0	528,654	0	0	0	0	0	0	0	0	528,654	21
22	Employee Benefits & Payroll Taxes	0	0	53,238	0	0	0	0	0	0	0	0	53,238	22
23	Inservice Training & Education	0	(72)	1,674	0	0	0	0	0	0	0	0	1,602	23
24	Travel and Seminar	(6,687)	0	6,611	0	0	0	0	0	0	0	0	(76)	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	88,195	0	0	0	0	0	0	0	0	88,195	26
27	Other (specify):*	11,290	0	0	0	0	0	0	0	0	0	0	11,290	27
28	TOTAL General Administration	(37,179)	(425,470)	700,625	0	0	0	0	0	0	0	0	237,976	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(37,179)	(451,173)	773,996	0	0	0	0	0	0	0	0	285,644	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Peru # 0048090 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	248,774	0	29,800	0	0	0	0	0	0	0	278,574	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,762)	113,383	0	3,345	0	0	0	0	0	0	0	111,966	32
33	Real Estate Taxes	0	54,666	0	0	0	0	0	0	0	0	0	54,666	33
34	Rent-Facility & Grounds	0	(565,020)	0	9,175	0	0	0	0	0	0	0	(555,845)	34
35	Rent-Equipment & Vehicles	0	0	0	16,243	0	0	0	0	0	0	0	16,243	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(4,762)	(148,197)	0	58,563	0	0	0	0	0	0	0	(94,396)	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	213,203	0	239	0	0	0	0	0	0	0	213,442	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	213,203	0	239	0	0	0	0	0	0	0	213,442	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(41,941)	(386,167)	773,996	58,802	0	0	0	0	0	0	0	404,690	45

Facility Name & ID Number Heritage Health Peru # 0048090 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Adjustment for Related Organiza	\$	GreenTree Pharmacy		\$ (25,703)	\$ (25,703)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy		(72)	(72)	2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy		213,203	213,203	3
4	V	19	Adjustment for Related Organization	425,398	Heritage Operations Group, LLC			(425,398)	4
5	V								5
6	V	34	Adjustment for Related Organization	565,020	Heritage Manor Real Estate, LLC			(565,020)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		54,666	54,666	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		106,947	106,947	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		248,774	248,774	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		6,436	6,436	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 990,418			\$ 604,251	\$ * (386,167)	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		\$ 6,196	\$ 6,196	15
16	V	2	Food Purchase		Heritage Operations Group		(22)	(22)	16
17	V	3	Housekeeping		Heritage Operations Group		8,261	8,261	17
18	V	4	Laundry		Heritage Operations Group		590	590	18
19	V	5	Heat & Other Utilities		Heritage Operations Group		1,967	1,967	19
20	V	6	Maintenance		Heritage Operations Group		24,108	24,108	20
21	V	7	Other		Heritage Operations Group		0	0	21
22	V	9	Medical Director		Heritage Operations Group		0	0	22
23	V	10	Nursing & Medical Records		Heritage Operations Group		32,087	32,087	23
24	V	11	Activities		Heritage Operations Group		7	7	24
25	V	12	Social Service		Heritage Operations Group		177	177	25
26	V	13	Nurse Aide Training		Heritage Operations Group		0	0	26
27	V	14	Program Transportation		Heritage Operations Group		0	0	27
28	V	15	Other		Heritage Operations Group		0	0	28
29	V	17	Administrative		Heritage Operations Group		0	0	29
30	V	18	Directors Fees		Heritage Operations Group		0	0	30
31	V	19	Professional Services		Heritage Operations Group		21,033	21,033	31
32	V	20	Fees, Subscription, Promotions		Heritage Operations Group		1,220	1,220	32
33	V	21	Clerical & General Office Expenses		Heritage Operations Group		528,654	528,654	33
34	V	22	Employee Benefits & Payroll Taxes		Heritage Operations Group		53,238	53,238	34
35	V	23	Inservice Training & Education		Heritage Operations Group		1,674	1,674	35
36	V	24	Travel and Seminar		Heritage Operations Group		6,611	6,611	36
37	V	25	Other Admin. Staff Transportation		Heritage Operations Group		0	0	37
38	V	26	Insurance-Prop.Liab.Malpract		Heritage Operations Group		88,195	88,195	38
39	Total			\$			\$ 773,996	\$ * 773,996	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	\$ 0	15
16	V	30			Heritage Operations Group		29,800	29,800	16
17	V	31			Heritage Operations Group		0	0	17
18	V	32			Heritage Operations Group		3,345	3,345	18
19	V	33			Heritage Operations Group		0	0	19
20	V	34			Heritage Operations Group		9,175	9,175	20
21	V	35			Heritage Operations Group		16,243	16,243	21
22	V	36			Heritage Operations Group		0	0	22
23	V	38			Heritage Operations Group		0	0	23
24	V	39			Heritage Operations Group		239	239	24
25	V	40			Heritage Operations Group		0	0	25
26	V	41			Heritage Operations Group		0	0	26
27	V	42			Heritage Operations Group		0	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			\$			\$ 58,802	\$ * 58,802	39

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

Facility Name & ID Number Heritage Health Peru # 0048090 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Heritage Health Peru# 0048090

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	127	\$ 6,196	1
2	2	Food Purchase	Beds	2,493	25	(423)	0	127	(22)	2
3	3	Housekeeping	Beds	2,493	25	162,156	0	127	8,261	3
4	4	Laundry	Beds	2,493	25	11,591	0	127	590	4
5	5	Heat & Other Utilities	Beds	2,493	25	38,605	0	127	1,967	5
6	6	Maintenance	Beds	2,493	25	473,233	88,567	127	24,108	6
7	7	Other	Beds	2,493	25	0	0	127	0	7
8	9	Medical Director	Beds	2,493	25	0	0	127	0	8
9	10	Nursing & Medical Records	Beds	2,493	25	629,872	35,401	127	32,087	9
10	11	Activities	Beds	2,493	25	129	0	127	7	10
11	12	Social Service	Beds	2,493	25	3,478	3,478	127	177	11
12	13	Nurse Aide Training	Beds	2,493	25	0	0	127	0	12
13	14	Program Transportation	Beds	2,493	25	0	0	127	0	13
14	15	Other	Beds	2,493	25	0	0	127	0	14
15	17	Administrative	Beds	2,493	25	0	0	127	0	15
16	18	Directors Fees	Beds	2,493	25	0	0	127	0	16
17	19	Professional Services	Beds	2,493	25	412,869	0	127	21,033	17
18	20	Fees, Subscription, Promotions	Beds	2,493	25	23,945	0	127	1,220	18
19	21	Clerical & General Office Expense	Beds	2,493	25	10,377,428	9,978,005	127	528,654	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,493	25	1,045,059	0	127	53,238	20
21	23	Inservice Training & Education	Beds	2,493	25	32,865	0	127	1,674	21
22	24	Travel and Seminar	Beds	2,493	25	129,776	0	127	6,611	22
23	25	Other Admin. Staff Transportation	Beds	2,493	25	0	0	127	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,493	25	1,731,253	0	127	88,195	24
25	TOTALS					\$ 15,193,470	\$ 10,226,789		\$ 773,996	25

Facility Name & ID Number Heritage Health Peru# 0048090

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	\$	127	\$	1
2	30	Depreciation	Beds	2,493	25	584,981	127	29,800	2
3	31	Amortization of Pre-Op & Org	Beds	2,493	25		127		3
4	32	Interest	Beds	2,493	25	65,658	127	3,345	4
5	33	Real Estate Taxes	Beds	2,493	25		127		5
6	34	Rent-Facility & Grounds	Beds	2,493	25	180,106	127	9,175	6
7	35	Rent-Equipment & Vehicles	Beds	2,493	25	318,843	127	16,243	7
8	36	Other	Beds	2,493	25		127		8
9	38	Medically Nec Transportation	Beds	2,493	25		127		9
10	39	Ancillary Service Centers	Beds	2,493	25	4,685	127	239	10
11	40	Barber and Beauty Shops	Beds	2,493	25		127		11
12	41	Coffee and Gift Shops	Beds	2,493	25		127		12
13	42	Other	Beds	2,493	25		127		13
14									14
15									15
16									16
17									17
18									18
19					9,978,005				19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 11,132,278	\$		\$ 58,802	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			\$				\$	106,947	1
2	Busey Bank		xx	Loan Fee Amortization								6,436	2
3													3
4													4
5													5
	Working Capital												
6	Busey Bank		xx	Working Capital								63,680	6
7													7
8													8
9	TOTAL Facility Related						\$				\$	177,063	9
	B. Non-Facility Related*												
10	Interest Income											(4,762)	10
11													11
12	Allocated Corporate											3,345	12
13													13
14	TOTAL Non-Facility Related						\$				\$	(1,417)	14
15	TOTALS (line 9+line14)						\$				\$	175,646	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.)			\$54,666	2
3. Under or (over) accrual (line 2 minus line 1).			\$54,666	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.			\$54,666	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2015	50,571	8	
	2016	54,500	9	
	2017	54,160	10	
	2018	54,662	11	
	2019	54,666	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 Peru COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0048090

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

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES xx NO

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:

36,520

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			1988	\$ 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	127				\$ 391,963	\$		\$	\$	4
5					325,293					5
6					153,474					6
7					677,402					7
8										8
	Improvement Type**									
9	1978 Improvements		1978		6,059					9
10	1979 Improvements		1979		9,952					10
11	1980 Improvements		1980		28,648					11
12	1981 Improvements		1981		8,175					12
13	1982 Improvements		1982		39,938					13
14	1983 Improvements		1983		13,985					14
15	1984 Improvements		1984		19,793					15
16	1985 Improvements		1985		550					16
17	1986 Improvements		1986		22,120					17
18	1988 Improvements		1988		19,053					18
19	1989 Improvements		1989		25,453					19
20	1990 Improvements		1990		12,118					20
21	1991 Improvements		1991		19,157					21
22	1992 Improvements		1992		87,224					22
23	1993 Improvements		1993		43,270					23
24	1994 Improvements		1994		16,885					24
25	1995 Improvements		1995							25
26	1996 Improvements		1996		13,024					26
27	1997 Improvements		1997		296,841					27
28	1998 Improvements		1998		20,635					28
29	1999 Improvements		1999		85,772					29
30	2000 Improvements		2000		16,434					30
31	2001 Improvements		2001		9,167					31
32	2002 Improvements		2002		10,187					32
33										33
34	C/O Allocation					29,800		29,800		34
35	Book Depreciation					227,283		227,283		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 Peru

0048090

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 2003 Improvements	2003	\$ 13,789	\$		\$	\$	\$	37
38 2004 Improvements	2004	29,449						38
39 2005 Improvements	2005	83,170						39
40 2006 Improvements	2006	55,277						40
41 2007 Improvements	2007	286,795						41
42 2008 Improvements	2008	59,381						42
43 2009 Improvements	2009	1,007,348						43
44 2010 Improvements	2010	722,961						44
45 2011 Improvements	2011	42,280						45
46 2012 Improvements	2012	17,509						46
47 2013 Improvements	2013	181,269						47
48 2014 Improvements	2014	47,860						48
49								49
50 Circuit and wire installation for wall mounted heaters	2015	5,820						50
51 New air condensing unit - middle hallway	2015	4,628						51
52 New air handler (5 ton) - entry way	2015	5,387						52
53 Replace sewer line	2015	37,614						53
54 Radiator replacement	2015	3,624						54
55 Install 100 gallon water heater	2015	7,980						55
56 Replace sewer pipe and foundation wall	2015	6,580						56
57 Cabling - 30 Cat 6 to data room	2015	15,610						57
58								58
59 Install hot water storage tank	2016	10,291						59
60 Replace fire alarm wiring	2016	3,984						60
61 Repair sewer and concrete walkway	2016	9,798						61
62								62
63 Added (2) water cabinet heaters to therapy room and (9)	2017	29,286						63
64 cabinet heaters to various hallways throughout the facility								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 5,060,262	\$ 257,083		\$ 257,083	\$	\$	70

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

Facility Name & ID Number Heritage Health Peru

0048090

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		\$ 5,060,262	\$ 257,083		\$ 257,083	\$	\$	1
2									2
3	Added circulating pump to Boiler #1	2018	2,616						3
4	Installed heat detectors	2018	5,455						4
5	Installed addressable devices and circuits	2018	9,847						5
6									6
7	Install epoxy coating to shower room floors	2019	11,587						7
8	Replace backflow valves	2019	6,997						8
9									9
10	Replace gutters - East Courtyard	2020	5,260						10
11	Replace HVAC Condenser - East & West Short Hallways	2020	17,057						11
12	Install 4 ton condensing unit - Dining Room	2020	3,644						12
13	Replace rooftop exhaust fans over restrooms and common area	2020	20,117						13
14	Replace water heater	2020	11,832						14
15	Replace dry system piping	2020	6,350						15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,161,024	\$ 257,083		\$ 257,083	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,713,038	\$21,491	\$21,491	\$		\$	71
72	Current Year Purchases	23,097						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,736,135	\$21,491	\$21,491	\$		\$	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$6,947,159	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$278,574	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$278,574	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		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: \$38,215Description: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	\$		\$ 472,705	\$		\$ 472,705	1
2	Licensed Speech and Language Development Therapist		hrs			47,647			47,647	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			450,438	0		450,438	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				287,587		287,587	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					136,511			136,511	13
14	TOTAL			\$		\$ 1,107,301	\$ 287,587		\$ 1,394,888	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	\$ 1,144	\$	1
2	Cash-Patient Deposits	28,865		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	(189,709)		3
4	Supply Inventory (priced at FIFO)	13,788		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,442		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(257,347)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (401,817)	\$	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)	\$ (401,817)	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,865		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	299,175		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,123		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	12,535		36
37	Deferred Stimulus	234,782		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 593,480	\$	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)	\$ 593,480	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (995,297)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (401,817)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (779,491)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (779,491)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(215,806)	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)	\$ (215,806)	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)	\$ (995,297)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Health Peru

0048090

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	\$ 7,566,682	1
2	Discounts and Allowances for all Levels	(2,663,957)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,902,725	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,562,765	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,562,765	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	667,129	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	524,431	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	650	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,192,210	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,762	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,762	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)	\$ 8,662,462	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,321,700	31
32	Health Care	3,994,538	32
33	General Administration	1,919,021	33
	B. Capital Expense		
34	Ownership	670,346	34
	C. Ancillary Expense		
35	Special Cost Centers	972,663	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)*	\$ 8,878,268	40
41	Income before Income Taxes (line 30 minus line 40)**	(215,806)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (215,806)	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	1,985	2,068	\$ 77,339	\$ 37.40	1
2	Assistant Director of Nursing	2,084	2,171	61,966	28.54	2
3	Registered Nurses	24,331	25,344	753,404	29.73	3
4	Licensed Practical Nurses	21,359	22,249	567,511	25.51	4
5	CNAs & Orderlies	91,779	95,603	1,515,580	15.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,913	4,076	85,557	20.99	8
9	Activity Director					9
10	Activity Assistants	8,021	8,355	160,216	19.18	10
11	Social Service Workers	3,263	3,399	70,604	20.77	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,893	21,763	271,797	12.49	15
16	Dishwashers					16
17	Maintenance Workers	8,677	9,038	150,069	16.60	17
18	Housekeepers	11,220	11,688	123,558	10.57	18
19	Laundry	3,304	3,442	40,481	11.76	19
20	Administrator	2,002	2,085	101,194	48.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,640	13,167	327,268	24.86	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)	215,471	224,448	\$ 4,306,544 *	\$ 19.19	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		\$ 8,169	L1 C3	35
36	Medical Director		28,421	L9 C3	36
37	Medical Records Consultant		614	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		7,231	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		1,845	L12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 46,280		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0		50
51	Licensed Practical Nurses		0		51
52	Certified Nurse Assistants/Aides		6,523	L10 C3	52
53	TOTAL (lines 50 - 52)		\$ 6,523		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount	
Lori Walsh	Administrator		\$ 101,194	Workers' Compensation Insurance		\$ 33,470	IDPH License Fee		\$	
				Unemployment Compensation Insurance		13,021	Advertising: Employee Recruitment		4,400	
				FICA Taxes		329,451	Health Care Worker Background Check			
				Employee Health Insurance		220,819	(Indicate # of checks performed)		2,283	
				Employee Meals			Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*						
				Other Benefits		75,790	PR		12,050	
				Central Office Allocation		53,238	Dues & Subscriptions		10,607	
							License & Fees		273	
							Central Office Allocation		1,220	
							Less: Public Relations Expense		(12,050)	
							Non-allowable advertising		(6,162)	
							Yellow page advertising		()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							TOTAL (agree to Sch. V, line 20, col. 8)		\$ 12,621	
B. Administrative - Other										
Description			Amount							
			\$							
			\$							
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)										
C. Professional Services										
Vendor/Payee	Type		Amount	Description		Line #	Amount			
Heritage Operations Group	Management		\$ 430,209				\$		Out-of-State Travel	\$
									In-State Travel	
										4,615
										35
									Seminar Expense	425
										(76)
									Entertainment Expense	()
Legal adj to Zero			12,880							
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 443,089	TOTAL			\$		TOTAL (agree to Sch. V, line 24, col. 8)	\$ 4,999

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No

(2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

HCCI - \$8,889

(3)

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

Yes

Yes

(4)

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

No

(5)

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

Yes

7 Yrs

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 5,000

Line 10

(7)

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

Yes

(8)

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

No

(9)

Are you presently operating under a sublease agreement?

YES

xx

NO

(10)

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

xx

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 231,847

(12)

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

No

(13)

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

Yes

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
For example, is a portion of the building used for rental, a pharmacy, day care, etc.)
If YES, attach a schedule which explains how all related costs were allocated to these functions.

No

(15)

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

\$ 0

Yes

Indicate the amount. \$ 445

(16)

Travel and Transportation

a.

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

No

b.

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

No

c.

What percent of all travel expense relates to transportation of nurses and patients?

100%

d.

Have vehicle usage logs been maintained?

Yes

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

NA

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No

\$ 0

(17)

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

Yes

MCK CPA's & Advisors

(18)

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

Yes

(19)

Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees.

None Claimed

HFS 3745 (9-4-06)

Heritage Manor - Peru
IDPH ID# 48090
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	\$ 287,587
Purchased Hospital Services	29,369
Purchased Laboratory Services	100,469
Purchased Radiology Services	6,673
Amount Reclassified to Line 39	\$ <u>424,098</u>

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

<u>Line Item</u>	
Provider Participation Fee - \$1.50	\$ (69,723)
Provider Assesment Fee - \$6.07	<u>(162,124)</u>
	\$ <u>(231,847)</u>
Provider Participation Fee	\$ <u>231,847</u>

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

<u>Line Item</u>	
Pharmacy Consulting Fee	\$ <u>7,231</u>