

		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: 0041699 Facility Name: Heritage Health Springfield Address: 900 North Rutledge Springfield 62702 County: Sangamon Telephone Number: (217) 789-0930 Fax # () HFS ID Number: Date of Initial License for Current Owners: 1996 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code xx PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. xx 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) (Type or Print Name) David M Underwood (Title) EVP & CFO Paid Preparer (Signed) (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
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Facility Name & ID Number Heritage Health Springfield

0041699 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>178</u>	Skilled (SNF)	<u>178</u>	<u>65,148</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>178</u>	TOTALS	<u>178</u>	<u>65,148</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>29,437</u>	<u>10,653</u>	<u>6,960</u>	<u>47,050</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>29,437</u>	<u>10,653</u>	<u>6,960</u>	<u>47,050</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.22%

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 1996

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 1996 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 178 and days of care provided 6,960

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 Springfield # 0041699 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	459,636	46,940	9,693	516,269		516,269	8,685	524,954			1
2	Food Purchase		428,256		428,256		428,256	(30)	428,226			2
3	Housekeeping	314,380	77,222		391,602		391,602	11,578	403,180			3
4	Laundry	130,853	12,464		143,317		143,317	828	144,145			4
5	Heat and Other Utilities			176,693	176,693		176,693	2,756	179,449			5
6	Maintenance	169,155	101,598	214,931	485,684		485,684	33,789	519,473			6
7	Other (specify):*											7
8	TOTAL General Services	1,074,024	666,480	401,317	2,141,821		2,141,821	57,606	2,199,427			8
	B. Health Care and Programs											
9	Medical Director			86,250	86,250		86,250		86,250			9
10	Nursing and Medical Records	4,120,613	370,937	1,032,963	5,524,513	(25,300)	5,499,213	(274)	5,498,939			10
10a	Therapy		750,085	70,746	820,831	(794,980)	25,851		25,851			10a
11	Activities	119,256	1,415		120,671		120,671	9	120,680			11
12	Social Services	129,124		3,212	132,336		132,336	248	132,584			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,368,993	1,122,437	1,193,171	6,684,601	(820,280)	5,864,321	(17)	5,864,304			16
	C. General Administration											
17	Administrative	113,026			113,026		113,026		113,026			17
18	Directors Fees											18
19	Professional Services			488,995	488,995		488,995	(427,628)	61,367			19
20	Dues, Fees, Subscriptions & Promotions			400,871	400,871	(351,582)	49,289	(21,690)	27,599			20
21	Clerical & General Office Expenses	683,565	41,841	25,216	750,622		750,622	740,948	1,491,570			21
22	Employee Benefits & Payroll Taxes			1,227,442	1,227,442		1,227,442	74,617	1,302,059			22
23	Inservice Training & Education			439	439		439	2,203	2,642			23
24	Travel and Seminar			186	186		186	4,813	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			100,941	100,941		100,941	123,611	224,552			26
27	Other (specify):* Lost resident items			316,335	316,335		316,335	(316,158)	177			27
28	TOTAL General Administration	796,591	41,841	2,560,425	3,398,857	(351,582)	3,047,275	180,716	3,227,991			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,239,608	1,830,758	4,154,913	12,225,279	(1,171,862)	11,053,417	238,305	11,291,722			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			908,238	908,238		908,238	41,768	950,006			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			290,247	290,247		290,247	761	291,008			32
33	Real Estate Taxes			98,911	98,911		98,911		98,911			33
34	Rent-Facility & Grounds							12,860	12,860			34
35	Rent-Equipment & Vehicles			119,524	119,524		119,524	22,765	142,289			35
36	Other (specify):*											36
37	TOTAL Ownership			1,416,920	1,416,920		1,416,920	78,154	1,495,074			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,258,402	1,258,402	820,280	2,078,682	176,152	2,254,834			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					351,582	351,582		351,582			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			1,258,402	1,258,402	1,171,862	2,430,264	176,152	2,606,416			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,239,608	1,830,758	6,830,235	14,900,601		14,900,601	492,611	15,393,212			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	(3,927)			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	(5,808)			17
18	Fines and Penalties	(2,158)			18
19	Entertainment	(4,453)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(52,391)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(314,000)			24
25	Fund Raising, Advertising and Promotional	(17,592)			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)	\$ (400,329)		\$	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)	892,940		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 892,940		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 492,611		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		(52,391)	19	11
12		(3,927)	32	12
13		(314,000)	27	13
14		(17,592)	20	14
15		(5,808)	20	15
16		(2,158)	27	16
17		(4,453)	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	(400,329)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Springfield# 0041699

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	8,685	0	0	0	0	0	0	0	0	8,685	1
2	Food Purchase	0	0	(30)	0	0	0	0	0	0	0	0	(30)	2
3	Housekeeping	0	0	11,578	0	0	0	0	0	0	0	0	11,578	3
4	Laundry	0	0	828	0	0	0	0	0	0	0	0	828	4
5	Heat and Other Utilities	0	0	2,756	0	0	0	0	0	0	0	0	2,756	5
6	Maintenance	0	0	33,789	0	0	0	0	0	0	0	0	33,789	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	57,606	0	0	0	0	0	0	0	0	57,606	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	(45,247)	44,973	0	0	0	0	0	0	0	0	(274)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	9	0	0	0	0	0	0	0	0	9	11
12	Social Services	0	0	248	0	0	0	0	0	0	0	0	248	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	(45,247)	45,230	0	0	0	0	0	0	0	0	(17)	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	(52,391)	(404,716)	29,479	0	0	0	0	0	0	0	0	(427,628)	19
20	Fees, Subscriptions & Promotions	(23,400)	0	1,710	0	0	0	0	0	0	0	0	(21,690)	20
21	Clerical & General Office Expenses	0	0	740,948	0	0	0	0	0	0	0	0	740,948	21
22	Employee Benefits & Payroll Taxes	0	0	74,617	0	0	0	0	0	0	0	0	74,617	22
23	Inservice Training & Education	0	(144)	2,347	0	0	0	0	0	0	0	0	2,203	23
24	Travel and Seminar	(4,453)	0	9,266	0	0	0	0	0	0	0	0	4,813	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	123,611	0	0	0	0	0	0	0	0	123,611	26
27	Other (specify):*	(316,158)	0	0	0	0	0	0	0	0	0	0	(316,158)	27
28	TOTAL General Administration	(396,402)	(404,860)	981,978	0	0	0	0	0	0	0	0	180,716	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(396,402)	(450,107)	1,084,814	0	0	0	0	0	0	0	0	238,305	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Springfield # 0041699 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	0	0	41,768	0	0	0	0	0	0	0	41,768	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,927)	0	0	4,688	0	0	0	0	0	0	0	761	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	12,860	0	0	0	0	0	0	0	12,860	34
35	Rent-Equipment & Vehicles	0	0	0	22,765	0	0	0	0	0	0	0	22,765	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,927)	0	0	82,081	0	0	0	0	0	0	0	78,154	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	175,817	0	335	0	0	0	0	0	0	0	176,152	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	175,817	0	335	0	0	0	0	0	0	0	176,152	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(400,329)	(274,290)	1,084,814	82,416	0	0	0	0	0	0	0	492,611	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
Heritage Enterprises, Inc.	50	Attached Following This Page		Heritage Operations G	Bloomington	Mgmt. Services
Memorial Health Ventures	50			Green Tree Pharmacy	Minonk	Pharmacy
				Memorial Medical Cen	Springfield	Acute Care Hospital

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		\$ (45,247)	\$ (45,247)	1	
2	V	23 Adjustment for Related Organization		GreenTree Pharmacy		(144)	(144)	2	
3	V	39 Adjustment for Related Organization		GreenTree Pharmacy		175,817	175,817	3	
4	V	19 Adjustment for Related Organization	404,716	Heritage Operations Group, LLC			(404,716)	4	
5	V							5	
6	V							6	
7	V							7	
8	V							8	
9	V							9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$ 404,716			\$ 130,426	\$ * (274,290)	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		\$ 8,685	\$ 8,685	15
16	V	2	Food Purchase		Heritage Operations Group		(30)	(30)	16
17	V	3	Housekeeping		Heritage Operations Group		11,578	11,578	17
18	V	4	Laundry		Heritage Operations Group		828	828	18
19	V	5	Heat & Other Utilities		Heritage Operations Group		2,756	2,756	19
20	V	6	Maintenance		Heritage Operations Group		33,789	33,789	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		44,973	44,973	23
24	V	11	Activities		Heritage Operations Group		9	9	24
25	V	12	Social Service		Heritage Operations Group		248	248	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		29,479	29,479	31
32	V	20	Fees, Subscription, Promotions		Heritage Operations Group		1,710	1,710	32
33	V	21	Clerical & General Office Expenses		Heritage Operations Group		740,948	740,948	33
34	V	22	Employee Benefits & Payroll Taxes		Heritage Operations Group		74,617	74,617	34
35	V	23	Inservice Training & Education		Heritage Operations Group		2,347	2,347	35
36	V	24	Travel and Seminar		Heritage Operations Group		9,266	9,266	36
37	V	25	Other Admin. Staff Transportation		Heritage Operations Group		0		37
38	V	26	Insurance-Prop.Liab.Malpract		Heritage Operations Group		123,611	123,611	38
39	Total			\$			\$ 1,084,814	\$ * 1,084,814	39

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

VII. RELATED PARTIES (continued)

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

xx

YES

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	\$	Heritage Operations Group		\$ 0	\$	15
16	V	30	Depreciation		Heritage Operations Group		41,768	41,768	16
17	V	31	Amortization of Pre-Op & Org		Heritage Operations Group		0		17
18	V	32	Interest		Heritage Operations Group		4,688	4,688	18
19	V	33	Real Estate Taxes		Heritage Operations Group		0		19
20	V	34	Rent-Facility & Grounds		Heritage Operations Group		12,860	12,860	20
21	V	35	Rent-Equipment & Vehicles		Heritage Operations Group		22,765	22,765	21
22	V	36	Other		Heritage Operations Group		0		22
23	V	38	Medically Nec Transportation		Heritage Operations Group		0		23
24	V	39	Ancillary Service Centers		Heritage Operations Group		335	335	24
25	V	40	Barber and Beauty Shops		Heritage Operations Group		0		25
26	V	41	Coffee and Gift Shops		Heritage Operations Group		0		26
27	V	42	Other		Heritage Operations Group		0		27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 82,416	\$ * 82,416	39

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

Facility Name & ID Number Heritage Health Springfield # 0041699 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	Heritage Enterprises Inc.			50.00	0	0			\$ 0		1
2	Memorial Health Ventures			50.00	0	0			0		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 Springfield# 0041699

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	178	\$ 8,685	1
2	2	Food Purchase	Beds	2,493	25	(423)	0	178	(30)	2
3	3	Housekeeping	Beds	2,493	25	162,156	0	178	11,578	3
4	4	Laundry	Beds	2,493	25	11,591	0	178	828	4
5	5	Heat & Other Utilities	Beds	2,493	25	38,605	0	178	2,756	5
6	6	Maintenance	Beds	2,493	25	473,233	88,567	178	33,789	6
7	7	Other	Beds	2,493	25	0	0	178	0	7
8	9	Medical Director	Beds	2,493	25	0	0	178	0	8
9	10	Nursing & Medical Records	Beds	2,493	25	629,872	35,401	178	44,973	9
10	11	Activities	Beds	2,493	25	129	0	178	9	10
11	12	Social Service	Beds	2,493	25	3,478	3,478	178	248	11
12	13	Nurse Aide Training	Beds	2,493	25	0	0	178	0	12
13	14	Program Transportation	Beds	2,493	25	0	0	178	0	13
14	15	Other	Beds	2,493	25	0	0	178	0	14
15	17	Administrative	Beds	2,493	25	0	0	178	0	15
16	18	Directors Fees	Beds	2,493	25	0	0	178	0	16
17	19	Professional Services	Beds	2,493	25	412,869	0	178	29,479	17
18	20	Fees, Subscription, Promotions	Beds	2,493	25	23,945	0	178	1,710	18
19	21	Clerical & General Office Expense	Beds	2,493	25	10,377,428	9,978,005	178	740,948	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,493	25	1,045,059	0	178	74,617	20
21	23	Inservice Training & Education	Beds	2,493	25	32,865	0	178	2,347	21
22	24	Travel and Seminar	Beds	2,493	25	129,776	0	178	9,266	22
23	25	Other Admin. Staff Transportation	Beds	2,493	25	0	0	178	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,493	25	1,731,253	0	178	123,611	24
25	TOTALS					\$ 15,193,470	\$ 10,226,789		\$ 1,084,814	25

Facility Name & ID Number Heritage Health Springfield # 0041699 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Heritage Operations Group
Street Address 115 W Jefferson Street
City / State / Zip Code Bloomington, IL 61701
Phone Number (309 828-4361
Fax Number (309 829-5477

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,493	25	\$	\$	178	\$	1
2	30	Depreciation	Beds	2,493	25	584,981		178	41,768	2
3	31	Amortization of Pre-Op & Org	Beds	2,493	25			178		3
4	32	Interest	Beds	2,493	25	65,658		178	4,688	4
5	33	Real Estate Taxes	Beds	2,493	25			178		5
6	34	Rent-Facility & Grounds	Beds	2,493	25	180,106		178	12,860	6
7	35	Rent-Equipment & Vehicles	Beds	2,493	25	318,843		178	22,765	7
8	36	Other	Beds	2,493	25			178		8
9	38	Medically Nec Transportation	Beds	2,493	25			178		9
10	39	Ancillary Service Centers	Beds	2,493	25	4,685		178	335	10
11	40	Barber and Beauty Shops	Beds	2,493	25			178		11
12	41	Coffee and Gift Shops	Beds	2,493	25			178		12
13	42	Other	Beds	2,493	25			178		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	\$		\$ 82,416	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	Bank of Springfield		xx	Mortgage			\$				\$ 287,708	1
2	Bank of Springfield		xx	Loan Fee Amortization							2,539	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$				\$ 290,247	9
	B. Non-Facility Related*											
10	Interest Income										(3,927)	10
11												11
12	Allocated Corporate										4,688	12
13												13
14	TOTAL Non-Facility Related						\$				\$ 761	14
15	TOTALS (line 9+line14)						\$				\$ 291,008	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.		\$	151,939	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.)				\$	127,238	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(24,701)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	133,600	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 \$ 9,988 For 17 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	(9,988)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	98,911	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2015	122,050	8	FOR BHF USE ONLY	
		2016	123,244	9		
		2017	141,706	10		
		2018	144,703	11		
		2019	127,238	12		
Accrual = 2019 taxes paid in 2019 * 1.05				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 Springfield COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0041699

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

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

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

A. Square Feet: 64,520

B. General Construction Type: Exterior Brick Frame Wood Number of Stories 4

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			1985	\$ 200,000	1
2			1996	430,000	2
3	TOTALS			\$ 630,000	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	178				\$ 1,900,000	\$		\$	\$	4
5					1,648,258					5
6										6
7										7
8										8
	Improvement Type**									
9	1985 Improvements		1985		26,076					9
10	1986 Improvements		1986		216,545					10
11	1987 Improvements		1987		593,121					11
12	1988 Improvements		1988		29,321					12
13	1989 Improvements		1989		1,095					13
14	1990 Improvements		1990		939					14
15	1991 Improvements		1991		32,022					15
16	1992 Improvements		1992		32,593					16
17	1993 Improvements		1993		105,986					17
18	1994 Improvements		1994		59,542					18
19	1995 Improvements		1995		36,126					19
20	1996 Improvements		1996		26,011					20
21	1997 Improvements		1997		104,210					21
22	1998 Improvements		1998		11,420					22
23	1999 Improvements		1999		13,575					23
24	2000 Improvements		2000		4,941					24
25	2001 Improvements		2001		827,192					25
26	2002 Improvements		2002		214,188					26
27	2003 Improvements		2003		22,841					27
28	2004 Improvements		2004		119,806					28
29	2005 Improvements		2005		24,396					29
30	2006 Improvements		2006		274,466					30
31	2007 Improvements		2007		72,732					31
32										32
33										33
34	C/O Allocation					41,768		41,768		34
35	Book Depreciation					749,504		749,504		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 Springfield

0041699

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38	2008 Improvements	2008	1,597					38
39	2009 Improvements	2009	77,275					39
40	2010 Improvements	2010	195,370					40
41	2011 Improvements	2011	35,852					41
42	2012 Improvements	2012	22,880					42
43	2013 Improvements	2013	42,227					43
44	2014 Improvements	2014	336,155					44
45								45
46	Replace boilers	2015	11,125					46
47	Install steel covering on kitchen hood	2015	3,494					47
48	Replace fire alarm control panel	2015	23,965					48
49								49
50	Replaced kitchen exhaust fan	2017	5,456					50
51	Replaced sump pump	2017	2,654					51
52								52
53	Facility wide modernization project consisting primarily of:	2017	8,350,161					53
54	Construction of 19 bed SNF based hospice unit							54
55	Replacement of interior finishes on Floors 2-4. This includes wall repair and painting,							55
56	new ceiling tile, improved cabinetry for nursing stations, new tile							56
57	for shower rooms and new tilets and lavatories.							57
58	Install exterior insulating finish system between window columns							58
59	Re-asphalt and stripe parking lots							59
60	Install entirely new HVAC system including new hot water boiler, cooling tower and heat pumps							60
61	Replace existing water lines and sewer waste lines							61
62	Replace entire fire alarm, nurse call and basic telephone systems							62
63	Replace (2) aging emergency generators with single unit having multiple transfer switches							63
64	Replace door alarm and elopment systems							64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)		\$ 15,505,613	\$ 791,272		\$ 791,272	\$	70

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

Facility Name & ID Number Heritage Health Springfield

0041699

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		\$ 15,505,613	\$ 791,272		\$ 791,272	\$	\$	1
2									2
3	Install make up air unit (coil, controls and damper)	2018	7,893						3
4	Install new RTU - 1st Floor Wing	2018	62,250						4
5	Replace control board and key pad - Trane Chiller Unit	2018	4,338						5
6									6
7	Install new water coil - air conditioning unit	2019	4,365						7
8									8
9	Install new water heater	2020	11,058						9
10	Replace elevator keypads	2020	24,600						10
11									11
12									12
13									13
14									14
15									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)		\$ 15,620,117	\$ 791,272		\$ 791,272	\$	\$	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	\$ 2,830,983	\$ 158,734	\$ 158,734	\$		\$	71
72	Current Year Purchases	7,602						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,838,585	\$ 158,734	\$ 158,734	\$		\$	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		2008 Ford Van	2008	\$ 38,949	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 38,949	\$	\$	\$		\$	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)	\$ 19,127,651	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 950,006	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 950,006	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

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

15. Is Movable equipment rental included in building rental?☐ YES☐ NO
16. Rental Amount for movable equipment:\$109,696Description:Oxygen cylinders, Wound VAC's, humidifiers, air mattresses, copiers and televisions
(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	Various	2019 Dodge Caravan	\$851.00	\$9,828	17
18					18
19					19
20					20
21	TOTAL		\$851.00	\$9,828	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

COMMUNITY COLLEGE☐

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

HOURS PER CNA

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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

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

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

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

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

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

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 655,291	\$		\$ 655,291	1
2	Licensed Speech and Language Development Therapist		hrs			124,710			124,710	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			478,401	551		478,952	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				749,534		749,534	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					70,746			70,746	13
14	TOTAL			\$		\$ 1,329,148	\$ 750,085		\$ 2,079,233	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	\$ 429,742	\$	1
2	Cash-Patient Deposits	65,589		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,621,611		3
4	Supply Inventory (priced at FIFO)	150,847		4
5	Short-Term Investments			5
6	Prepaid Insurance	9,834		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(255,236)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,022,387	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	857,251		13
14	Buildings, at Historical Cost	15,496,985		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,839,138		16
17	Accumulated Depreciation (book methods)	(10,031,332)		17
18	Deferred Charges	1,664,909		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): Investment in Regency RE LLC	4,775,018		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 15,601,969	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 17,624,356	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,097,957	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	65,589		28
29	Short-Term Notes Payable	320,000		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	133,600		32
33	Accrued Interest Payable	20,903		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Bed Tax	20,286		36
37	Deferred Stimulus	396,742		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,055,077	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	6,374,051		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)	\$ 6,374,051	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,429,128	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,195,228	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 17,624,356	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,312,685	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,312,685	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,117,457)	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)	\$ (1,117,457)	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)	\$ 8,195,228	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Health Springfield

0041699

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	\$ 12,401,718	1
2	Discounts and Allowances for all Levels	(4,229,450)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,172,268	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,412,341	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,412,341	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	1,016,097	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	1,228,986	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(55,198)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,189,885	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,927	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,927	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund	14	28
28a	Nurse Training Reimbursement - Prior Year	4,709	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,723	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,783,144	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,141,821	31
32	Health Care	6,684,601	32
33	General Administration	3,398,857	33
	B. Capital Expense		
34	Ownership	1,416,920	34
	C. Ancillary Expense		
35	Special Cost Centers	1,258,402	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)*	\$ 14,900,601	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,117,457)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,117,457)	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	1,965	2,047	\$ 92,140	\$ 45.01	1
2	Assistant Director of Nursing	3,628	3,779	168,123	44.49	2
3	Registered Nurses	10,970	11,428	375,151	32.83	3
4	Licensed Practical Nurses	48,288	50,301	1,321,524	26.27	4
5	CNAs & Orderlies	113,022	117,731	2,064,385	17.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,792	4,991	99,290	19.89	8
9	Activity Director					9
10	Activity Assistants	8,757	9,122	119,256	13.07	10
11	Social Service Workers	6,481	6,751	129,124	19.13	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	35,927	37,424	459,636	12.28	15
16	Dishwashers					16
17	Maintenance Workers	8,681	9,042	169,155	18.71	17
18	Housekeepers	24,108	25,112	314,380	12.52	18
19	Laundry	9,264	9,649	130,853	13.56	19
20	Administrator	2,152	2,242	113,026	50.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	26,862	27,981	683,565	24.43	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)	304,897	317,600	\$ 6,239,608 *	\$ 19.65	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 9,693	L1 C3	35
36	Medical Director		86,250	L9 C3	36
37	Medical Records Consultant		1,462	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		25,300	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		3,212	L12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 125,917		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 472,268	L10 C3	50
51	Licensed Practical Nurses		365,243	L10 C3	51
52	Certified Nurse Assistants/Aides		168,690	L10 C3	52
53	TOTAL (lines 50 - 52)		\$ 1,006,201		53

Facility Name & ID Number		Heritage Health Springfield		STATE OF ILLINOIS		# 0041699		Report Period Beginning:		1/1/2020		Page 21		Ending: 12/31/2020	
XIX. SUPPORT SCHEDULES															
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions							
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount					
Maryann Walker		Administrator		\$ 113,026	Workers' Compensation Insurance		\$ 66,474	IDPH License Fee		\$					
					Unemployment Compensation Insurance		24,840	Advertising: Employee Recruitment		6,011					
					FICA Taxes		477,330	Health Care Worker Background Check							
					Employee Health Insurance		365,638	(Indicate # of checks performed)		6,788					
					Employee Meals			Patient Background Checks							
					Illinois Municipal Retirement Fund (IMRF)*										
								PR		4,729					
TOTAL (agree to Schedule V, line 17, col. 1)					Other Benefits		293,160	Dues & Subscriptions		15,586					
(List each licensed administrator separately.)				\$ 113,026	Central Office Allocation		74,617	License & Fees		3,312					
B. Administrative - Other															
Description				Amount				Central Office Allocation		1,710					
				\$				Less: Public Relations Expense		(4,729)					
								Non-allowable advertising		(5,808)					
								Yellow page advertising		()					
					TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,302,059	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 27,599					
TOTAL (agree to Schedule V, line 17, col. 3)								G. Schedule of Travel and Seminar**							
(Attach a copy of any management service agreement)															
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees											
Vendor/Payee		Type		Amount	Description		Line #	Amount	Description		Amount				
Heritage Operations Group		Management		\$ 409,506				\$	Out-of-State Travel		\$				
May Cocagne & King		Audit and tax		17,600											
McQuellon Consulting		Real estate tax matters		4,498											
Govig Inc.		Personnel recruitment		5,000					In-State Travel						
											87				
											31				
									Seminar Expense		68				
											4,813				
Legal adj to Zero				52,391					Entertainment Expense		()				
									(agree to Sch. V, line 24, col. 8)						
TOTAL (agree to Schedule V, line 19, column 3)					TOTAL		\$		TOTAL		\$ 4,999				
(For legal fee disclosure, see page 39 of instructions)				\$ 488,995											
										* Attach copy of IMRF notifications		**See instructions.			

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI - \$10,682
- (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. \$ 351,582
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. \$ 563
- (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 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 - Springfield
IDPH ID# 41699
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	\$ 749,534
Purchased Hospital Services	20,973
Purchased Laboratory Services	33,656
Purchased Radiology Services	16,117
Amount Reclassified to Line 39	\$ <u>820,280</u>

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

<u>Line Item</u>	
Provider Participation Fee - \$1.50	\$ (97,722)
Provider Assesment Fee - \$6.07	<u>(253,860)</u>
	\$ <u>(351,582)</u>
Provider Participation Fee	\$ <u>351,582</u>

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

<u>Line Item</u>	
Pharmacy Consulting Fees	\$ <u>25,300</u>