

		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: 0048066

Facility Name: Heritage Health Streator

Address: 1525 East Main St Streator 61364
Number City Zip Code

County: LaSalle

Telephone Number: (815) 672-4516 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners:

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)
(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

Facility Name & ID Number Heritage Health Streator

0048066 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	130	Skilled (SNF)	130	47,580	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	130	TOTALS	130	47,580	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	17,242	11,292	4,048	32,582	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,242	11,292	4,048	32,582	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.48%

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 130 and days of care provided 4,048

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 Streator # 0048066 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	629,131	33,437	8,366	670,934		670,934	6,343	677,277			1
2	Food Purchase		51,911		51,911		51,911	(22)	51,889			2
3	Housekeeping	161,596	47,413		209,009		209,009	8,456	217,465			3
4	Laundry	92,311	25,332		117,643		117,643	604	118,247			4
5	Heat and Other Utilities			128,798	128,798		128,798	2,013	130,811			5
6	Maintenance	104,537	66,998	131,881	303,416		303,416	24,677	328,093			6
7	Other (specify):*											7
8	TOTAL General Services	987,575	225,091	269,045	1,481,711		1,481,711	42,071	1,523,782			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	3,090,313	275,944	92,225	3,458,482	(9,050)	3,449,432	762	3,450,194			10
10a	Therapy		353,563	51,146	404,709	(393,856)	10,853		10,853			10a
11	Activities	70,486	4,561		75,047		75,047	7	75,054			11
12	Social Services	52,701		3,902	56,603		56,603	181	56,784			12
13	CNA Training	7,199	6,870		14,069		14,069		14,069			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,220,699	640,938	149,673	4,011,310	(402,906)	3,608,404	950	3,609,354			16
	C. General Administration											
17	Administrative	68,593			68,593		68,593		68,593			17
18	Directors Fees											18
19	Professional Services			495,869	495,869		495,869	(468,190)	27,679			19
20	Dues, Fees, Subscriptions & Promotions			318,728	318,728	(256,839)	61,889	(40,195)	21,694			20
21	Clerical & General Office Expenses	334,113	26,950	10,290	371,353		371,353	541,141	912,494			21
22	Employee Benefits & Payroll Taxes			923,761	923,761		923,761	54,496	978,257			22
23	Inservice Training & Education			180	180		180	1,534	1,714			23
24	Travel and Seminar			4,683	4,683		4,683	316	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			75,939	75,939		75,939	90,278	166,217			26
27	Other (specify):* Lost resident items			38,504	38,504		38,504	(38,202)	302			27
28	TOTAL General Administration	402,706	26,950	1,867,954	2,297,610	(256,839)	2,040,771	141,178	2,181,949			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,610,980	892,979	2,286,672	7,790,631	(659,745)	7,130,886	184,199	7,315,085			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							302,709	302,709			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			63,150	63,150		63,150	93,622	156,772			32
33	Real Estate Taxes							69,752	69,752			33
34	Rent-Facility & Grounds			569,400	569,400		569,400	(560,008)	9,392			34
35	Rent-Equipment & Vehicles			72,766	72,766		72,766	16,626	89,392			35
36	Other (specify):*											36
37	TOTAL Ownership			705,316	705,316		705,316	(77,299)	628,017			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,167,504	1,167,504	402,906	1,570,410	186,943	1,757,353			39
40	Barber and Beauty Shops		365	4,331	4,696		4,696		4,696			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					256,839	256,839		256,839			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		365	1,171,835	1,172,200	659,745	1,831,945	186,943	2,018,888			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,610,980	893,344	4,163,823	9,668,147		9,668,147	293,843	9,961,990			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	(655)			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	(7,011)			17
18	Fines and Penalties				18
19	Entertainment	(6,451)			19
20	Contributions	(500)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(13,861)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(37,702)			24
25	Fund Raising, Advertising and Promotional	(34,433)			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)	\$ (100,613)		\$	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)	394,456		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 394,456		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 293,843		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		(13,861)	19	11
12		(655)	32	12
13		(37,702)	27	13
14		(34,433)	20	14
15		(7,011)	20	15
16		(500)	27	16
17		(6,451)	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	(100,613)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Streator# 0048066

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	6,343	0	0	0	0	0	0	0	0	6,343	1
2	Food Purchase	0	0	(22)	0	0	0	0	0	0	0	0	(22)	2
3	Housekeeping	0	0	8,456	0	0	0	0	0	0	0	0	8,456	3
4	Laundry	0	0	604	0	0	0	0	0	0	0	0	604	4
5	Heat and Other Utilities	0	0	2,013	0	0	0	0	0	0	0	0	2,013	5
6	Maintenance	0	0	24,677	0	0	0	0	0	0	0	0	24,677	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	42,071	0	0	0	0	0	0	0	0	42,071	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	(32,083)	32,845	0	0	0	0	0	0	0	0	762	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	181	0	0	0	0	0	0	0	0	181	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	(32,083)	33,033	0	0	0	0	0	0	0	0	950	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	(13,861)	(475,858)	21,529	0	0	0	0	0	0	0	0	(468,190)	19
20	Fees, Subscriptions & Promotions	(41,444)	0	1,249	0	0	0	0	0	0	0	0	(40,195)	20
21	Clerical & General Office Expenses	0	0	541,141	0	0	0	0	0	0	0	0	541,141	21
22	Employee Benefits & Payroll Taxes	0	0	54,496	0	0	0	0	0	0	0	0	54,496	22
23	Inservice Training & Education	0	(180)	1,714	0	0	0	0	0	0	0	0	1,534	23
24	Travel and Seminar	(6,451)	0	6,767	0	0	0	0	0	0	0	0	316	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	90,278	0	0	0	0	0	0	0	0	90,278	26
27	Other (specify):*	(38,202)	0	0	0	0	0	0	0	0	0	0	(38,202)	27
28	TOTAL General Administration	(99,958)	(476,038)	717,174	0	0	0	0	0	0	0	0	141,178	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(99,958)	(508,121)	792,278	0	0	0	0	0	0	0	0	184,199	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Streator # 0048066 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	272,205	0	30,504	0	0	0	0	0	0	0	302,709	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(655)	90,853	0	3,424	0	0	0	0	0	0	0	93,622	32
33	Real Estate Taxes	0	69,752	0	0	0	0	0	0	0	0	0	69,752	33
34	Rent-Facility & Grounds	0	(569,400)	0	9,392	0	0	0	0	0	0	0	(560,008)	34
35	Rent-Equipment & Vehicles	0	0	0	16,626	0	0	0	0	0	0	0	16,626	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(655)	(136,590)	0	59,946	0	0	0	0	0	0	0	(77,299)	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	186,699	0	244	0	0	0	0	0	0	0	186,943	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	186,699	0	244	0	0	0	0	0	0	0	186,943	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(100,613)	(458,012)	792,278	60,190	0	0	0	0	0	0	0	293,843	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
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		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		\$ (32,083)	\$ (32,083)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy		(180)	(180)	2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy		186,699	186,699	3
4	V	19	Adjustment for Related Organization	475,858	Heritage Operations Group, LLC			(475,858)	4
5	V								5
6	V	34	Adjustment for Related Organization	569,400	Heritage Manor Real Estate, LLC			(569,400)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		69,752	69,752	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		85,710	85,710	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		272,205	272,205	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		5,143	5,143	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,045,258			\$ 587,246	\$ * (458,012)	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		\$ 6,343	\$ 6,343	15
16	V	2	Food Purchase		Heritage Operations Group		(22)	(22)	16
17	V	3	Housekeeping		Heritage Operations Group		8,456	8,456	17
18	V	4	Laundry		Heritage Operations Group		604	604	18
19	V	5	Heat & Other Utilities		Heritage Operations Group		2,013	2,013	19
20	V	6	Maintenance		Heritage Operations Group		24,677	24,677	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		32,845	32,845	23
24	V	11	Activities		Heritage Operations Group		7	7	24
25	V	12	Social Service		Heritage Operations Group		181	181	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		21,529	21,529	31
32	V	20	Fees, Subscription, Promotions		Heritage Operations Group		1,249	1,249	32
33	V	21	Clerical & General Office Expenses		Heritage Operations Group		541,141	541,141	33
34	V	22	Employee Benefits & Payroll Taxes		Heritage Operations Group		54,496	54,496	34
35	V	23	Inservice Training & Education		Heritage Operations Group		1,714	1,714	35
36	V	24	Travel and Seminar		Heritage Operations Group		6,767	6,767	36
37	V	25	Other Admin. Staff Transportation		Heritage Operations Group		0		37
38	V	26	Insurance-Prop.Liab.Malpract		Heritage Operations Group		90,278	90,278	38
39	Total			\$			\$ 792,278	\$ * 792,278	39

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

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27		\$	Heritage Operations Group		\$ 0	\$	15
16	V	30			Heritage Operations Group		30,504	30,504	16
17	V	31			Heritage Operations Group		0		17
18	V	32			Heritage Operations Group		3,424	3,424	18
19	V	33			Heritage Operations Group		0		19
20	V	34			Heritage Operations Group		9,392	9,392	20
21	V	35			Heritage Operations Group		16,626	16,626	21
22	V	36			Heritage Operations Group		0		22
23	V	38			Heritage Operations Group		0		23
24	V	39			Heritage Operations Group		244	244	24
25	V	40			Heritage Operations Group		0		25
26	V	41			Heritage Operations Group		0		26
27	V	42			Heritage Operations Group		0		27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 60,190	\$ * 60,190	39

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

Facility Name & ID Number Heritage Health Streator # 0048066 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 Streator# 0048066

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	130	\$ 6,343	1
2	2	Food Purchase	Beds	2,493	25	(423)	0	130	(22)	2
3	3	Housekeeping	Beds	2,493	25	162,156	0	130	8,456	3
4	4	Laundry	Beds	2,493	25	11,591	0	130	604	4
5	5	Heat & Other Utilities	Beds	2,493	25	38,605	0	130	2,013	5
6	6	Maintenance	Beds	2,493	25	473,233	88,567	130	24,677	6
7	7	Other	Beds	2,493	25	0	0	130	0	7
8	9	Medical Director	Beds	2,493	25	0	0	130	0	8
9	10	Nursing & Medical Records	Beds	2,493	25	629,872	35,401	130	32,845	9
10	11	Activities	Beds	2,493	25	129	0	130	7	10
11	12	Social Service	Beds	2,493	25	3,478	3,478	130	181	11
12	13	Nurse Aide Training	Beds	2,493	25	0	0	130	0	12
13	14	Program Transportation	Beds	2,493	25	0	0	130	0	13
14	15	Other	Beds	2,493	25	0	0	130	0	14
15	17	Administrative	Beds	2,493	25	0	0	130	0	15
16	18	Directors Fees	Beds	2,493	25	0	0	130	0	16
17	19	Professional Services	Beds	2,493	25	412,869	0	130	21,529	17
18	20	Fees, Subscription, Promotions	Beds	2,493	25	23,945	0	130	1,249	18
19	21	Clerical & General Office Expense	Beds	2,493	25	10,377,428	9,978,005	130	541,141	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,493	25	1,045,059	0	130	54,496	20
21	23	Inservice Training & Education	Beds	2,493	25	32,865	0	130	1,714	21
22	24	Travel and Seminar	Beds	2,493	25	129,776	0	130	6,767	22
23	25	Other Admin. Staff Transportation	Beds	2,493	25	0	0	130	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,493	25	1,731,253	0	130	90,278	24
25	TOTALS					\$ 15,193,470	\$ 10,226,789		\$ 792,278	25

Facility Name & ID Number Heritage Health Streator# 0048066

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	\$	130	\$	1
2	30	Depreciation	Beds	2,493	25	584,981	130	30,504	2
3	31	Amortization of Pre-Op & Org	Beds	2,493	25		130		3
4	32	Interest	Beds	2,493	25	65,658	130	3,424	4
5	33	Real Estate Taxes	Beds	2,493	25		130		5
6	34	Rent-Facility & Grounds	Beds	2,493	25	180,106	130	9,392	6
7	35	Rent-Equipment & Vehicles	Beds	2,493	25	318,843	130	16,626	7
8	36	Other	Beds	2,493	25		130		8
9	38	Medically Nec Transportation	Beds	2,493	25		130		9
10	39	Ancillary Service Centers	Beds	2,493	25	4,685	130	244	10
11	40	Barber and Beauty Shops	Beds	2,493	25		130		11
12	41	Coffee and Gift Shops	Beds	2,493	25		130		12
13	42	Other	Beds	2,493	25		130		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	\$		\$ 60,190	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			\$					\$ 85,710	1
2	Busey Bank		xx	Loan Fee Amortization								5,143	2
3													3
4													4
5													5
	Working Capital												
6	Busey Bank		xx	Working Capital								63,150	6
7													7
8													8
9	TOTAL Facility Related						\$					\$ 154,003	9
	B. Non-Facility Related*												
10	Interest Income											(655)	10
11													11
12	Allocated Corporate											3,424	12
13													13
14	TOTAL Non-Facility Related						\$					\$ 2,769	14
15	TOTALS (line 9+line14)						\$					\$ 156,772	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.)			\$69,752	2
3. Under or (over) accrual (line 2 minus line 1).			\$69,752	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.			\$69,752	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2015	63,739	8	
	2016	68,946	9	
	2017	72,345	10	
	2018	72,790	11	
	2019	69,752	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 Streator COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0048066

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: 39,770

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).
Evergreen Place-Streator - (53) unit supportive living facility - grounds are adjacent but buildings are separated.
Services are not shared.

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				\$ 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	130				\$ 348,848	\$		\$	\$	4
5					440,122					5
6					2,594,839					6
7										7
8										8
9	Improvement Type**									
10	1980 Improvements		1980		12,172					9
11	1981 Improvements		1981		13,748					10
12	1982 Improvements		1982		18,366					11
13	1983 Improvements		1983		9,250					12
14	1984 Improvements		1984		1,329					13
15	1985 Improvements		1985		4,100					14
16	1986 Improvements		1986		57,336					15
17	1988 Improvements		1988		6,225					16
18	1989 Improvements		1989		48,818					17
19	1990 Improvements		1990		22,687					18
20	1991 Improvements		1991		31,584					19
21	1992 Improvements		1992		3,560					20
22	1993 Improvements		1993		19,172					21
23	1994 Improvements		1994		23,135					22
24	1995 Improvements		1995		61,264					23
25	1996 Improvements		1996		3,910					24
26	1997 Improvements		1997		303,615					25
27	1998 Improvements		1998		14,471					26
28	1999 Improvements		1999		3,675					27
29	2000 Improvements		2000		6,510					28
30	2001 Improvements		2001		48,428					29
31	2002 Improvements		2002		70,668					30
32	2003 Improvements		2003		9,315					31
33										32
34	C/O Allocation					30,504		30,504		33
35	Book Depreciation					197,911		197,911		34
36										35
										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 Streator

0048066

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	
37	2004 Improvements	2004	\$ 10,481	\$		\$	\$	\$	37
38	2005 Improvements	2005	113,995						38
39	2006 Improvements	2006	85,199						39
40	2007 Improvements	2007	241,527						40
41	2008 Improvements	2008	113,324						41
42	2009 Improvements	2009	29,017						42
43	2010 Improvements	2010	20,685						43
44	2011 Improvements	2011	97,087						44
45	2012 Improvements	2012	189,872						45
46	2013 Improvements	2013	237,537						46
47	2014 Improvements	2014	353,611						47
48									48
49	Installed (2) new hot water heater expansion tanks	2015	3,785						49
50	Install electric heat in air handlers - NE and NW wings	2015	9,295						50
51	Completion of 2014 renovation to corridors 100&200 -	2015	3,650						51
52	asbestos abatement								52
53	Replace (4) wood doors	2015	3,440						53
54	Flooring replacement - Rec Room	2015	5,334						54
55	Nurse call system upgrade - telephonic and electrical upgrades	2015	33,961						55
56									56
57	No 2016 Improvements								57
58									58
59	Installed new water softener	2017	7,636						59
60	Upgraded 2015 nurse call system electronics	2017	5,088						60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,741,671	\$ 228,415		\$ 228,415	\$	\$	70

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

Facility Name & ID Number Heritage Health Streator

0048066

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	
1 Totals from Page 12A, Carried Forward		\$ 5,741,671	\$ 228,415		\$ 228,415	\$	\$	1
2								2
3 Install new condensing unit	2018	6,275						3
4								4
5 Remove and replace chimney with partial repair of roof	2019	64,262						5
6 Repair parking lot and main driveway	2019	7,080						6
7								7
8 No 2020 Improvements	2020							8
9								9
10								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)		\$ 5,819,288	\$ 228,415		\$ 228,415	\$	\$	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	\$1,700,972	\$68,074	\$68,074	\$		\$	71
72	Current Year Purchases	21,442						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,722,414	\$68,074	\$68,074	\$		\$	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		2017 Dodge Grand SW	2016	\$43,540	\$6,220	\$6,220	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$43,540	\$6,220	\$6,220	\$		\$	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)	\$7,635,242	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$302,709	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$302,709	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: \$72,766Description:Supplies, 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			\$	\$	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		6,870		6,870
3	Classroom Wages (a)				
4	Clinical Wages (b)		7,199		7,199
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 14,069	\$	\$ 14,069
10	SUM OF line 9, col. 1 and 2 (e)	\$ 14,069			

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

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

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

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

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

\$
- D. NUMBER OF CNAs TRAINED

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 542,482	\$		\$ 542,482	1
2	Licensed Speech and Language Development Therapist		hrs			99,471			99,471	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			525,551	1,803		527,354	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				351,760		351,760	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					51,146			51,146	13
14	TOTAL			\$		\$ 1,218,650	\$ 353,563		\$ 1,572,213	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	\$ 863	\$	1
2	Cash-Patient Deposits	14,860		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	(84,359)		3
4	Supply Inventory (priced at FIFO)	27,346		4
5	Short-Term Investments			5
6	Prepaid Insurance	535		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	2,186,999		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,146,244	\$	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)	\$ 2,146,244	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,860		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	461,485		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,300		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	13,214		36
37	Deferred Stimulus	158,586		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 650,445	\$	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)	\$ 650,445	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,495,799	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,146,244	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,422,955	1
2	Restatements (describe):		2
3	Rounding	6	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,422,961	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	72,838	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)	\$ 72,838	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,495,799	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Health Streator

0048066

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	\$ 8,103,694	1
2	Discounts and Allowances for all Levels	(3,040,971)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,062,723	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,516,183	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,516,183	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	672,384	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,914	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	448,211	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	35,915	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,161,424	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	655	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 655	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)	\$ 9,740,985	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,481,711	31
32	Health Care	4,011,310	32
33	General Administration	2,297,610	33
	B. Capital Expense		
34	Ownership	705,316	34
	C. Ancillary Expense		
35	Special Cost Centers	1,172,200	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)*	\$ 9,668,147	40
41	Income before Income Taxes (line 30 minus line 40)**	72,838	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 72,838	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	1,940	2,020	\$ 72,329	\$ 35.81	1
2	Assistant Director of Nursing	1,897	1,976	68,155	34.49	2
3	Registered Nurses	26,658	27,769	953,699	34.34	3
4	Licensed Practical Nurses	14,365	14,964	457,670	30.58	4
5	CNAs & Orderlies	91,915	95,744	1,538,460	16.07	5
6	CNA Trainees	769	801	7,199	8.99	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,698	4,894	70,486	14.40	10
11	Social Service Workers	1,985	2,068	52,701	25.48	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	51,527	53,674	629,131	11.72	15
16	Dishwashers					16
17	Maintenance Workers	5,444	5,671	104,537	18.43	17
18	Housekeepers	14,155	14,745	161,596	10.96	18
19	Laundry	7,488	7,800	92,311	11.83	19
20	Administrator	1,714	1,786	68,593	38.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,645	21,505	334,113	15.54	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)	245,200	255,417	\$ 4,610,980 *	\$ 18.05	34

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		\$ 8,366	L1 C3	35
36	Medical Director		2,400	L9 C3	36
37	Medical Records Consultant		667	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		9,050	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		3,902	L12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 24,385		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 10,254	L10 C3	50
51	Licensed Practical Nurses		9,597	L10 C3	51
52	Certified Nurse Assistants/Aides		61,834	L10 C3	52
53	TOTAL (lines 50 - 52)		\$ 81,685		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Bonnie Bradley	Administrator		\$ 68,593
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 68,593
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
Heritage Operations Group	Management		\$ 482,008
Legal adj to Zero			13,861
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 495,869
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 61,871
Unemployment Compensation Insurance			19,263
FICA Taxes			352,740
Employee Health Insurance			327,761
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Other Benefits			162,126
Central Office Allocation			54,496
TOTAL (agree to Schedule V, line 22, col.8)			\$ 978,257
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			6,866
Health Care Worker Background Check (Indicate # of checks performed)			3,392
Patient Background Checks			
PR			23,410
Dues & Subscriptions			11,560
License & Fees			5,638
Central Office Allocation			1,249
Less: Public Relations Expense			(23,410)
Non-allowable advertising			(7,011)
Yellow page advertising			()
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 21,694
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
			2,884
			0
Seminar Expense			1,799
			316
Entertainment Expense			()
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 4,999

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI - \$9,102

(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. \$ 256,839
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 275,522

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

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

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

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

Heritage Manor - Streator
IDPH ID# 48066
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	\$ 351,760
Purchased Hospital Services	10,749
Purchased Laboratory Services	31,902
Purchased Radiology Services	8,495
Amount Reclassified to Line 39	\$ <u>402,906</u>

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

<u>Line Item</u>	
Provider Participation Fee - \$1.50	\$ (71,370)
Provider Assesment Fee - \$6.07	<u>(185,469)</u>
	\$ <u>(256,839)</u>
Provider Participation Fee	\$ <u>256,839</u>

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

<u>Line Item</u>	
Pharmacy Consultant Expense	\$ <u>9,050</u>