

		FOR BHF USE					

LL1

2025

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

FINANCIAL AND STATISTICAL REPORT (COST REPORT)

FOR LONG-TERM CARE FACILITIES

(FISCAL YEAR 2025)

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: 0052027

Facility Name: Heritage Health Hoopeston

Address: 423 N Dixie Highway Hoopeston 60942
Number City Zip Code

County: Vermilion

Telephone Number: (217) 283-8247 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: 2012

Type of Ownership:

xx VOLUNTARY, NON-PROFIT
xx Charitable Corp.
Trust
IRS Exemption Code 501 C 3

PROPRIETARY GOVERNMENTAL
Individual State
Partnership County
Corporation Other
"Sub-S" Corp.
Limited Liability Co.
Trust
Other

In the event there are further questions about this report, please contact:
Name: Daniel Curry Telephone Number: 309-823-7164
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 01/01/2025 to 12/31/2025 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) Daniel Curry
(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
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number Heritage Health Hoopeston # 0052027 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	75	Skilled (SNF)	75	27,375	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	75	TOTALS	75	27,375	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	4,184	11,215	3,415		6,332	326	228	25,700	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	4,184	11,215	3,415		6,332	326	228	25,700	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 93.88%

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 2012

J. Was the facility purchased or leased after January 1, 1978? YES ☐ Date Built in 2011 NO ☒

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 75

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL ☒ 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 Hoopeston # 0052027 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	285,894	24,517	6,960	317,371		317,371		317,371			1
2	Food Purchase		221,137		221,137		221,137		221,137			2
3	Housekeeping	136,403	41,710		178,113		178,113		178,113			3
4	Laundry		142,004		142,004		142,004		142,004			4
5	Heat and Other Utilities			124,625	124,625		124,625	(2,925)	121,700			5
6	Maintenance	110,534	102,501	35,590	248,625		248,625	(94,405)	154,220			6
7	Other (specify):*											7
8	TOTAL General Services	532,831	531,869	167,175	1,231,875		1,231,875	(97,330)	1,134,545			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,539,782	72,419	25,336	2,637,537	91,734	2,729,271		2,729,271			10
10a	Therapy		43,284	1,952	45,236	(39,321)	5,915		5,915			10a
11	Activities	98,350	6,476		104,826		104,826		104,826			11
12	Social Services			1,468	1,468		1,468		1,468			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,638,132	122,179	40,756	2,801,067	52,413	2,853,480		2,853,480			16
	C. General Administration											
17	Administrative	107,572			107,572		107,572		107,572			17
18	Directors Fees											18
19	Professional Services			410,141	410,141	(1,753)	408,388	(18,385)	390,003			19
20	Dues, Fees, Subscriptions & Promotions			526,215	526,215	(488,681)	37,534	(22,312)	15,222			20
21	Clerical & General Office Expenses	232,513	31,144	128,362	392,019	(95,896)	296,123		296,123			21
22	Employee Benefits & Payroll Taxes			513,388	513,388		513,388		513,388			22
23	Inservice Training & Education			1,120	1,120		1,120		1,120			23
24	Travel and Seminar			1,726	1,726		1,726		1,726			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			199,323	199,323		199,323	(18,496)	180,827			26
27	Other (specify):* Lost Resident Items			13,658	13,658		13,658	(9,667)	3,991			27
28	TOTAL General Administration	340,085	31,144	1,793,933	2,165,162	(586,330)	1,578,832	(68,860)	1,509,972			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,511,048	685,192	2,001,864	6,198,104	(533,917)	5,664,187	(166,190)	5,497,997			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			240,497	240,497		240,497	(42,566)	197,931			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			187,960	187,960		187,960	(1,563)	186,397			32
33	Real Estate Taxes			112,151	112,151		112,151	(44,465)	67,686			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			34,068	34,068		34,068		34,068			35
36	Other (specify):*											36
37	TOTAL Ownership			574,676	574,676		574,676	(88,594)	486,082			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			159,773	159,773	45,236	205,009		205,009			39
40	Barber and Beauty Shops			251	251		251		251			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					488,681	488,681		488,681			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			160,024	160,024	533,917	693,941		693,941			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,511,048	685,192	2,736,564	6,932,804		6,932,804	(254,784)	6,678,020			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	(82,271)			6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,563)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(798)			13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(6,525)			17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(50)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(18,385)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,819)			24
25	Fund Raising, Advertising and Promotional	(15,710)			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 Non care property costs	(120,663)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (254,784)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (254,784)		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	xx		1,466	10a	42
43	Prescription Drugs	xx		43,284	10a	43
44	Hospital Services	xx		486	10a	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 45,236		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (6,525)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Rental property - Professional Fees		19	3
4	Rental property - Liability Insurance	(18,496)	26	4
5	Rental property - Real Estate Taxes	(44,465)	33	5
6	Rental property - Heat and Other Utilities	(2,925)	5	6
7	Rental property - Repairs and Maintenance	(12,134)	6	7
8	Rental property - Housekeeping		3	8
9	Rental property - Depreciation Expense	(42,566)	30	9
10	Rental property - Fees	(77)	20	10
11		(8,819)	27	11
12		(1,563)	32	12
13		(798)	27	13
14		(9,185)	20	14
15		(6,525)	20	15
16		(82,271)	6	16
17		(50)	27	17
18		(18,385)	19	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	(254,784)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

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
Hoopeston Retirement Village Foundation (An Illinois Not For Profit Corporation) (List of Board Members is attached)	100	None		None		

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			\$			\$	\$	1
2	V								2
3	V								3
4	V								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			\$			\$	\$ *	14

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

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Board Members are not compensated								\$		1
2	for their services										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

Ending: 2/31/2025

Fax Number

	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
2										2
3										3
4										4
5										5
6										6
7										7
8										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	TOTALS					\$	\$		\$	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	USDA		xx	Mortgage			\$	4,732,343			\$	187,960	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$	4,732,343			\$	187,960	9
	B. Non-Facility Related*												
10	Interest Income											(1,563)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	(1,563)	14
15	TOTALS (line 9+line14)						\$	4,732,343			\$	186,397	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.)

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,865 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [xx] (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? [xx] (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. List the bed capacity for the building if it differs from the licensed total. Same
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? No
J. 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.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES [xx] 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:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	Nursing Facility			2010	\$	200,000	1
2							2
3	TOTALS				\$	200,000	3

Facility Name & ID Number Heritage Health Hoopeston

0052027

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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	75			2012	\$ 6,101,158	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	2013 Improvements			2013	66,643					9
10	2014 Improvements			2014	93,176					10
11	2015 Improvements			2015	16,058					11
12	2016 Improvements			2016	12,109					12
13	2017 Improvements			2017	9,180					13
14	2018 Improvements - None			2018						14
15	2019 Improvements			2019	3,570					15
16										16
17	Replaced flooring - main dining area			2020	7,168					17
18	Improved parking lot - filled cracks, patched and sealed			2020	9,100					18
19										19
20	Upgrade automatic door operator			2021	15,677					20
21	Install chain link fence			2021	9,500					21
22										22
23	Install LED fixtures in the main parking lot			2022	6,450					23
24	Install new "panic" bars - kitchen door			2022	4,424					24
25	Built concrete access road from Route 1 to main parking lot			2022	24,000					25
26										26
27	Install new tank style air compressor for dry sprinkler fire system			2023	8,227					27
28	Replace panic bars on left and right hand side of outer			2023	3,487					28
29	main entrance door									29
30										30
31										31
32										32
33										33
34	Rental Property Depreciation					(42,566)		(42,566)		34
35	Book Depreciation					231,443		231,443		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

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	Replaced water heater	2024	\$ 42,950	\$		\$	\$	\$	37
38	Replaced chiller compressor	2024	3,876						38
39									39
40	Removed and replaced (3) exterior windows	2025	3,172						40
41	Installed new stainless steel Octave water meter	2025	3,712						41
42	Installed new Norton electric hold door opener/closer	2025	4,908						42
43	Repalced (2) failed sewage lift station pumps and reconnected	2025	34,308						43
44	all wiring thereto								44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,482,853	\$ 188,877		\$ 188,877	\$	\$	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$651,876	\$9,054	\$9,054	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$651,876	\$9,054	\$9,054	\$		\$	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		2015 Grand Caravan	2016	\$40,593	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$40,593	\$	\$	\$		\$	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)	\$7,375,322	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$197,931	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$197,931	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	Multiple single family houses	\$	\$	\$	86
87	in the city of Hoopeston	1,402,376	42,566	530,537	87
88					88
89					89
90					90
91	TOTALS	\$1,402,376	\$42,566	\$530,537	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: \$34,068Description:Oxygen concentrators, copiers and printers
(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	None		\$	\$	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.

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2026	\$
13.	/2027	\$
14.	/2028	\$

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES☐ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

COMMUNITY COLLEGE☐

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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	

(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	\$		\$ 77,515	\$		\$ 77,515	1
2	Licensed Speech and Language Development Therapist		hrs			12,103			12,103	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			70,155	0		70,155	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				43,284		43,284	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					1,952			1,952	13
14	TOTAL			\$		\$ 161,725	\$ 43,284		\$ 205,009	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.

Facility Name & ID Number	Heritage Health Hoopeston
---------------------------	---------------------------

0052027

Report Period Beginning: 01/01/2025

Ending:

12/31/2025

XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2025**

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 481,483	\$	1
2	Cash-Patient Deposits	13,180		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	594,157		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,573		6
7	Other Prepaid Expenses	10,486		7
8	Accounts Receivable (owners or related parties)	(466,496)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 654,383	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	238,426		13
14	Buildings, at Historical Cost	8,413,818		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	697,441		16
17	Accumulated Depreciation (book methods)	(3,507,099)		17
18	Deferred Charges	135,021		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec Debt Svc Reserve	393,051		22
23	Other(specify): <u>Investment in RRG (Trinity)</u>	66,951		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,437,609	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,091,992	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 176,242	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,180		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	100,702		32
33	Accrued Interest Payable	3,890		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Bed Tax</u>	39,760		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 333,774	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,732,343		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)	\$ 4,732,343	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,066,117	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,025,875	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,091,992	\$	48

***(See instructions.)**

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$1,889,896	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$1,889,895	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	135,980	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)	\$135,980	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)	\$2,025,875	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Health Hoopeston

0052027

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

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	\$ 6,729,882	1
2	Discounts and Allowances for all Levels	(211,699)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,518,183	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	288,754	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 288,754	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	125,185	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	82,271	16
17	Sale of Drugs	52,867	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(39)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 260,284	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,563	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,563	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)	\$ 7,068,784	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,231,875	31
32	Health Care	2,801,067	32
33	General Administration	2,165,162	33
	B. Capital Expense		
34	Ownership	574,676	34
	C. Ancillary Expense		
35	Special Cost Centers	160,024	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)*	\$ 6,932,804	40
41	Income before Income Taxes (line 30 minus line 40)**	135,980	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 135,980	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 970,444.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	2,588,236.32	45
46	MMAI-Medicaid is the Primary Payer	788,017.68	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	1,976,691.14	48
49	Medicare Part A	135,417.00	49
50	Other-(specify)		50
51	Other-(specify) Private Insurance	71,056.86	51
52	Other-(specify) Medicare Cost Report Settlement	2,487.00	52
53	Other-(specify) Medicare Bad Debts	-14,167.00	53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,518,183	56

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	1,968	2,072	\$ 98,887	\$ 47.73	1
2	Assistant Director of Nursing	4,064	4,278	190,659	44.57	2
3	Registered Nurses	13,323	14,024	624,892	44.56	3
4	Licensed Practical Nurses	5,549	5,842	193,292	33.09	4
5	CNAs & Orderlies	52,983	55,772	1,432,052	25.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,260	5,537	98,350	17.76	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,713	16,540	285,894	17.29	15
16	Dishwashers					16
17	Maintenance Workers	5,180	5,453	110,534	20.27	17
18	Housekeepers	7,798	8,209	136,403	16.62	18
19	Laundry					19
20	Administrator	2,044	2,151	107,572	50.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,008	8,430	232,513	27.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					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)	121,890	128,308	\$ 3,511,048 *	\$ 27.36	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		\$ 6,960	Ln 1 Col 3	35
36	Medical Director		12,000	Ln 9 Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,915	Ln 10a Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		1,468	Ln 12 Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 26,343		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	303	10,026	Ln10 Col 3	52
53	TOTAL (lines 50 - 52)	303	\$ 10,026		53

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

** See instructions.

Facility Name & ID Number	Heritage Health Hoopeston
---------------------------	---------------------------

0052027

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.
- | Association Name | Amount |
|---|--------------------|
| <u>HEALTH CARE COUNCIL OF IL (HCCI)</u> | <u>6,525</u> |
| <u> </u> | <u> </u> |
| <u> </u> | <u> </u> |
| <u> </u> | <u>6,525</u> Total |
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.
- | | |
|---|--------------------|
| <u>HEALTH CARE COUNCIL OF IL (HCCI)</u> | <u>6,525</u> |
| <u> </u> | <u> </u> |
| <u> </u> | <u> </u> |
| <u> </u> | <u> </u> |
| <u> </u> | <u>6,525</u> Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|---|---------------------|
| <u>HEALTH CARE COUNCIL OF IL (HCCI)</u> | <u>13,050</u> |
| <u> </u> | <u> </u> |
| <u> </u> | <u> </u> |
| <u> </u> | <u> </u> |
| <u> </u> | <u>13,050</u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 488,681
This amount is to be recorded on line 42 of Schedule V.
- (8) 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.

- (9) 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
- (10) 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.
- (11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 820
- (12) 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. \$
- (13) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Russ Leigh & Assoc
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (15) 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.

[illegible]

Hoopeston Retirement Village Foundation
2025 Illinois Public Aid Cost Report
Supplemental Schedules
Reclassification Entries

1. Schedule V - Line 10a to Line 39 - Reclassifications

<u>Line Item</u>		
Purchased Drugs and Medications	\$	43,284
Purchased Hospital Services		486
Purchased Laboratory Services		198
Purchased Radiology Services		<u>1,268</u>
Amount Reclassified to Line 39	\$	<u><u>45,236</u></u>

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

<u>Line Item</u>		
Provider Participation Fee	\$	<u><u>488,681</u></u>

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

<u>Line Item</u>		
Pharmacy Consultant	\$	<u><u>5,915</u></u>

4. Schedule V - Line 21 to Line 10 - Reclass MDS and Medical Records Wages

<u>Line Item</u>		
MDS Coordinators/Care Planners - Line 21, Col 1	\$	(72,249)
Medical Records Specialists - Line 21, Col 1		<u>(23,647)</u>
	\$	<u><u>(95,896)</u></u>
Nursing & Medical Records Line 10	\$	<u><u>95,896</u></u>

5. Schedule V - Line 19 to Line 10 - Reclass MDS and Medical Records Consulting Fees

<u>Line Item</u>		
Professional Fees - Line 19	\$	<u><u>(1,753)</u></u>
Nursing & Medical Records - Line 10	\$	<u><u>1,753</u></u>