

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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.

<p>I. IDPH License ID Number: <u>0048116</u></p> <p>Facility Name: <u>Heritage Health-Gibson City</u></p> <p>Address: <u>620 E 1st St</u> <u>Gibson City</u> <u>60936</u> <small>Number City Zip Code</small></p> <p>County: <u>Ford</u></p> <p>Telephone Number: <u>(217) 784-4257</u> Fax # ()</p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>July 2006</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Craig Ater</u> Telephone Number: <u>(309) 823-7135</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/12</u> to <u>12/31/12</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Craig Ater</u> (Title) <u>Exec VP & CFO</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) _____ Fax # () </td> </tr> </table> <p align="right"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Craig Ater</u> (Title) <u>Exec VP & CFO</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) _____ Fax # ()
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Craig Ater</u> (Title) <u>Exec VP & CFO</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) _____ Fax # ()							

Facility Name & ID Number Heritage Health-Gibson City

0048116 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	27,450	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	27,450	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	14,588	4,851	1,411	20,850	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,588	4,851	1,411	20,850	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.96%

D. How many bed-hold days during this year were paid by the Department? _____

0 (Do not include bed-hold 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? _____

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 _____ and days of care provided 1,411

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-Gibson City

0048116

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	186,268	6,672		192,940		192,940	4,648	197,588		1
2	Food Purchase		140,672		140,672		140,672	34	140,706		2
3	Housekeeping	64,520	14,945		79,465		79,465		79,465		3
4	Laundry	47,269	7,555		54,824		54,824		54,824		4
5	Heat and Other Utilities			50,144	50,144		50,144	1,109	51,253		5
6	Maintenance	46,770	29,673	37,396	113,839		113,839	11,444	125,283		6
7	Other (specify):*										7
8	TOTAL General Services	344,827	199,517	87,540	631,884		631,884	17,235	649,119		8
	B. Health Care and Programs										
9	Medical Director			10,800	10,800		10,800	1,947	12,747		9
10	Nursing and Medical Records	1,105,547	95,546	6,985	1,208,078		1,208,078	1	1,208,079		10
10a	Therapy		208,757	254,864	463,621	(240,618)	223,003	90,410	313,413		10a
11	Activities	47,808	1,552		49,360		49,360		49,360		11
12	Social Services	34,121		3,010	37,131		37,131		37,131		12
13	CNA Training							776	776		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,187,476	305,855	275,659	1,768,990	(240,618)	1,528,372	93,134	1,621,506		16
	C. General Administration										
17	Administrative	74,370			74,370		74,370		74,370		17
18	Directors Fees										18
19	Professional Services			145,473	145,473		145,473	(133,162)	12,311		19
20	Dues, Fees, Subscriptions & Promotions			53,672	53,672	(41,175)	12,497	651	13,148		20
21	Clerical & General Office Expenses	124,377	17,439	10,605	152,421		152,421	211,134	363,555		21
22	Employee Benefits & Payroll Taxes			384,917	384,917		384,917	29,975	414,892		22
23	Inservice Training & Education			2,427	2,427		2,427	(428)	1,999		23
24	Travel and Seminar			3,725	3,725		3,725	(1,726)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			40,426	40,426		40,426	8,171	48,597		26
27	Other (specify):*			1,280	1,280		1,280	(1,180)	100		27
28	TOTAL General Administration	198,747	17,439	642,525	858,711	(41,175)	817,536	113,435	930,971		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,731,050	522,811	1,005,724	3,259,585	(281,793)	2,977,792	223,804	3,201,596		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.

Facility Name & ID Number Heritage Health-Gibson City

#0048116

Report Period Beginning:

01/01/12

Ending:

12/31/12

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation							107,502	107,502			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,221	18,221		18,221	34,878	53,099			32
33	Real Estate Taxes							33,640	33,640			33
34	Rent-Facility & Grounds			328,500	328,500		328,500	(323,755)	4,745			34
35	Rent-Equipment & Vehicles			32,466	32,466		32,466	732	33,198			35
36	Other (specify):*											36
37	TOTAL Ownership			379,187	379,187		379,187	(147,003)	232,184			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					240,618	240,618		240,618			39
40	Barber and Beauty Shops			3,605	3,605		3,605		3,605			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					41,175	41,175		41,175			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			3,605	3,605	281,793	285,398		285,398			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,731,050	522,811	1,388,516	3,642,377		3,642,377	76,801	3,719,178			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Heritage Health-Gibson City

0048116

Report Period Beginning: 01/01/12

Ending: 12/31/12

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-	BHF USE	
			ence	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	(2,979)			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)	(428)			16
17	Non-Care Related Fees	(360)			17
18	Fines and Penalties				18
19	Entertainment	(4,538)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,124)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,180)			24
25	Fund Raising, Advertising and Promotional	(4,595)			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)	\$ (16,204)		\$	30

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	2	
		Amount	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)	93,005		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 93,005		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 76,801		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY					
48		49		50	51
					52

Heritage Health-Gibson City

ID# 0048116

Report Period Beginning: 01/01/12

Ending: 12/31/12

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1		\$		1
2				2
3				3
4				4
5		0	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(360)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(2,124)	19	22
23				23
24		(1,180)	27	24
25		(4,595)	20	25
26				26
27				27
28				28
29			33	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		(8,259)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health-Gibson City# 0048116

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	4,648	0	0	0	0	0	0	0	0	4,648	1
2	Food Purchase	0	0	34	0	0	0	0	0	0	0	0	34	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,109	0	0	0	0	0	0	0	0	1,109	5
6	Maintenance	0	0	11,444	0	0	0	0	0	0	0	0	11,444	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	17,235	0	0	0	0	0	0	0	0	17,235	8
	B. Health Care and Programs													
9	Medical Director	0	0	1,947	0	0	0	0	0	0	0	0	1,947	9
10	Nursing and Medical Records	0	0	1	0	0	0	0	0	0	0	0	1	10
10a	Therapy	0	90,410	0	0	0	0	0	0	0	0	0	90,410	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	776	0	0	0	0	0	0	0	0	776	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	90,410	2,724	0	0	0	0	0	0	0	0	93,134	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	(2,124)	(143,349)	12,311	0	0	0	0	0	0	0	0	(133,162)	19
20	Fees, Subscriptions & Promotions	(4,955)	0	5,606	0	0	0	0	0	0	0	0	651	20
21	Clerical & General Office Expenses	0	0	211,134	0	0	0	0	0	0	0	0	211,134	21
22	Employee Benefits & Payroll Taxes	0	0	29,975	0	0	0	0	0	0	0	0	29,975	22
23	Inservice Training & Education	(428)	0	0	0	0	0	0	0	0	0	0	(428)	23
24	Travel and Seminar	(4,538)	0	2,812	0	0	0	0	0	0	0	0	(1,726)	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	8,171	0	0	0	0	0	0	0	0	8,171	26
27	Other (specify):*	(1,180)	0	0	0	0	0	0	0	0	0	0	(1,180)	27
28	TOTAL General Administration	(13,225)	(143,349)	270,009	0	0	0	0	0	0	0	0	113,435	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(13,225)	(52,939)	289,968	0	0	0	0	0	0	0	0	223,804	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health-Gibson City

0048116

Report Period Beginning:

01/01/12 Ending:

12/31/12

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	94,815	0	12,687	0	0	0	0	0	0	0	107,502	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,979)	37,565	0	292	0	0	0	0	0	0	0	34,878	32
33	Real Estate Taxes	0	33,608	0	32	0	0	0	0	0	0	0	33,640	33
34	Rent-Facility & Grounds	0	(328,500)	0	4,745	0	0	0	0	0	0	0	(323,755)	34
35	Rent-Equipment & Vehicles	0	0	0	732	0	0	0	0	0	0	0	732	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,979)	(162,512)	0	18,488	0	0	0	0	0	0	0	(147,003)	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	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(16,204)	(215,451)	289,968	18,488	0	0	0	0	0	0	0	76,801	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
<u>Heritage Enterprises, Inc.</u>	<u>100</u>	<u>See Pg 25</u>				

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
	V		\$			\$		1
2	V	<u>10a Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>	<u>0.00%</u>	<u>90,410</u>	<u>90,410</u>	2
3	V							3
4	V	<u>19 Adjustment for Related Organization</u>	<u>143,349</u>	<u>Heritage Operations Group, LLC</u>	<u>0.00%</u>		<u>(143,349)</u>	4
5	V							5
6	V	<u>34 Adjustment for Related Organization</u>	<u>328,500</u>	<u>Heritage Manor Real Estate, LLC</u>	<u>0.00%</u>		<u>(328,500)</u>	6
7	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>33,608</u>	<u>33,608</u>	7
8	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>32,792</u>	<u>32,792</u>	8
9	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>94,815</u>	<u>94,815</u>	9
10	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>4,773</u>	<u>4,773</u>	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 471,849			\$ 256,398	\$ * (215,451)	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 Enterprises, Inc.		\$	\$ 4,648	15
16	V	2 Food Purchase					34	16
17	V	3 Housekeeping					0	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					1,109	19
20	V	6 Maintenance					11,444	20
21	V	7 Other					0	21
22	V	9 Medical Director					1,947	22
23	V	10 Nursing & Medical Records					1	23
24	V	11 Activities					0	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					776	26
27	V	14 Program Transportation					0	27
28	V	15 Other					0	28
29	V	17 Administrative					0	29
30	V	18 Directors Fees					0	30
31	V	19 Professional Services					12,311	31
32	V	20 Fees, Subscription, Promotions					5,606	32
33	V	21 Clerical & General Office Expenses					211,134	33
34	V	22 Employee Benefits & Payroll Taxes					29,975	34
35	V	23 Inservice Training & Education					0	35
36	V	24 Travel and Seminar					2,812	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					8,171	38
39	Total		\$			\$	0	\$ * 289,968 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 Other	\$	Heritage Enterprises, Inc.		\$	\$	0 15
16	V	30 Depreciation						12,687 16
17	V	31 Amortization of Pre-Op & Org						0 17
18	V	32 Interest						292 18
19	V	33 Real Estate Taxes						32 19
20	V	34 Rent-Facility & Grounds						4,745 20
21	V	35 Rent-Equipment & Vehicles						732 21
22	V	36 Other						0 22
23	V	38 Medically Nec Transportation						0 23
24	V	39 Ancillary Service Centers						0 24
25	V	40 Barber and Beauty Shops						0 25
26	V	41 Coffee and Gift Shops						0 26
27	V	42 Other						0 27
28	V							
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V							
39	Total		\$			\$	\$	0 * 18,488 39

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

Facility Name & ID Number

Heritage Health-Gibson City

0048116

Report Period Beginning:

01/01/12

Ending:

12/31/12

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Heritage Health-Gibson City # 0048116 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	9
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Heritage Enterprises Inc.	Member	100.00					\$ 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-Gibson City

0048116

Report Period Beginning:

01/01/12

Ending: 12/31/12

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

Name of Related Organization Heritage Operations Group
 Street Address box 3188
 City / State / Zip Code Bloomington, IL 61701
 Phone Number ()
 Fax Number ()

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

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	1	Dietary	Beds	2,735	26	\$ 169,500	\$ 168,827	75	\$ 4,648	1
2	2	Food Purchase	Beds	2,735	26	1,241	0	75	34	2
3	3	Housekeeping	Beds	2,735	26	0	0	75	0	3
4	4	Laundry	Beds	2,735	26	0	0	75	0	4
5	5	Heat & Other Utilities	Beds	2,735	26	40,426	0	75	1,109	5
6	6	Maintenance	Beds	2,735	26	417,328	78,403	75	11,444	6
7	7	Other	Beds	2,735	26	0	0	75	0	7
8	9	Medical Director	Beds	2,735	26	71,007	0	75	1,947	8
9	10	Nursing & Medical Records	Beds	2,735	26	33	70,119	75	1	9
10	11	Activities	Beds	2,735	26	0	0	75	0	10
11	12	Social Service	Beds	2,735	26	0	0	75	0	11
12	13	Nurse Aide Training	Beds	2,735	26	28,290	22,496	75	776	12
13	14	Program Transportation	Beds	2,735	26	0	0	75	0	13
14	15	Other	Beds	2,735	26	0	0	75	0	14
15	17	Administrative	Beds	2,735	26	0	0	75	0	15
16	18	Directors Fees	Beds	2,735	26	0	0	75	0	16
17	19	Professional Services	Beds	2,735	26	448,954	0	75	12,311	17
18	20	Fees, Subscription, Promotions	Beds	2,735	26	204,427	0	75	5,606	18
19	21	Clerical & General Office Expens	Beds	2,735	26	7,699,360	7,229,609	75	211,134	19
20	22	Employee Benefits & Payroll Tax	Beds	2,735	26	1,093,087	0	75	29,975	20
21	23	Inservice Training & Education	Beds	2,735	26	0	0	75	0	21
22	24	Travel and Seminar	Beds	2,735	26	102,532	0	75	2,812	22
23	25	Other Admin. Staff Transportatio	Beds	2,735	26	0	0	75	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,735	26	297,962	0	75	8,171	24
25	TOTALS					\$ 10,574,147	\$ 7,569,454		\$ 289,968	25

Facility Name & ID Number Heritage Health-Gibson City

0048116

Report Period Beginning:

01/01/12

Ending: 12/31/12

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

Name of Related Organization Heritage Operations Group
 Street Address box 3188
 City / State / Zip Code Bloomington, IL 61701
 Phone Number ()
 Fax Number ()

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

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	2,735	26	\$	\$	75	\$	1
2	30	Depreciation	Beds	2,735	26	462,659	75	12,687		2
3	31	Amortization of Pre-Op & Org	Beds	2,735	26		75			3
4	32	Interest	Beds	2,735	26	10,650	75	292		4
5	33	Real Estate Taxes	Beds	2,735	26	1,164	75	32		5
6	34	Rent-Facility & Grounds	Beds	2,735	26	173,045	75	4,745		6
7	35	Rent-Equipment & Vehicles	Beds	2,735	26	26,702	75	732		7
8	36	Other	Beds	2,735	26		75			8
9	38	Medically Nec Transportation	Beds	2,735	26		75			9
10	39	Ancillary Service Centers	Beds	2,735	26		75			10
11	40	Barber and Beauty Shops	Beds	2,735	26		75			11
12	41	Coffee and Gift Shops	Beds	2,735	26		75			12
13	42	Other	Beds	2,735	26		75			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					\$ 674,220	\$		\$ 18,488	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	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	Bank of America		x	Mortgage			\$	\$ 603,265			\$ 32,792	1					
2	Bank of America		x	Loan Fee Amort							4,773	2					
3												3					
4												4					
5												5					
Working Capital																	
6	Bank of America		xx	Working Capital							18,221	6					
7												7					
8												8					
9	TOTAL Facility Related						\$	\$ 603,265			\$ 55,786	9					
B. Non-Facility Related*																	
10	Interest Income										(2,979)	10					
11												11					
12	Allocated Corporate										292	12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ (2,687)	14					
15	TOTALS (line 9+line14)						\$	\$ 603,265			\$ 53,099	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2011 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.)		\$	33,608		2	
3. Under or (over) accrual (line 2 minus line 1).		\$	33,608		3	
4. Real Estate Tax accrual used for 2012 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.		\$	33,608		7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2007	_____	8	FOR BHF USE ONLY		
	2008	_____	9			
	2009	_____	10			
	2010	_____	11			
	2011	33,608	12			
				13	FROM R. E. TAX STATEMENT FOR 2011 \$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Health-Gibson City COUNTY Ford

FACILITY IDPH LICENSE NUMBER 0048116

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>091111482001</u>	_____	\$ 33,459.00	\$ 33,608.00
2.	<u>091111479017</u>	_____	\$ 149.00	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>33,608.00</u>	\$ <u>33,608.00</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).
none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ 20,000	1
2					2
3	TOTALS			\$ 20,000	3

Facility Name & ID Number Heritage Health-Gibson City

0048116

Report Period Beginning:

01/01/12

Ending:

12/31/12

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			\$ 815,350	\$		\$	\$	\$
5				912,769					
6									
7									
8									
	Improvement Type**								
9	1981 Improvements	1981		41,753					
10	1982 Improvements	1982		6,437					
11	1983 Improvements	1983		240					
12	1984 Improvements	1984		873					
13	1985 Improvements	1985		7,530					
14	1986 Improvements	1986		20,979					
15	1987 Improvements	1987		2,222					
16	1988 Improvements	1988		2,452					
17	1989 Improvements	1989		28,639					
18	1990 Improvements	1990		99,326					
19	1991 Improvements	1991		36,637					
20	1993 Improvements	1993		40,838					
21	1994 Improvements	1994		66,399					
22	1995 Improvements	1995		1,060					
23	WINDOW REPLACEMENTS	1996		25,247					
24	WATER HEATER	1996		1,639					
25	RESIDENT ROOM REMODEL/PAINTING	1996		7,584					
26	Parking Lot	1998		12,299					
27									
28	Smoke Dampers	1999		5,256					
29	Water Heater	1999		1,971					
30	Garbage Disposal	1999		1,693					
31	Heat/Cool compressor	1999		3,277					
32	Smoke Dampers	2000		1,295					
33	C/O Allocation				12,687			(12,687)	
34	Book Depreciation				74,256		74,256		
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-Gibson City

0048116

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	Temperature Control Unit	2001	\$ 1,700	\$		\$	\$	\$	37
38	AC Replacement	2001	4,400						38
39	Smoke Detection System								39
40									40
41	Smoke Detection System	2002	1,775						41
42	Landscaping	2002	1,425						42
43	Fire Supression	2002	4,458						43
44	Water Heater	2002	2,396						44
45	Keypad Perimeter	2002	941						45
46	Sealcoat Parking Lot	2002	1,371						46
47	Garbage Disposal	2002	1,520						47
48	Hot Water Tank	2002	3,168						48
49	Rehab Hallway--Wallpaper/Paint	2002	14,442						49
50									50
51	Exterior Doors	2003	2,195						51
52	Roof Replacement	2003	28,555						52
53	Security Door	2003	1,116						53
54	Water Heater	2003	1,999						54
55	Water Tank	2003	1,836						55
56									56
57	HVAC unit	2004	5,247						57
58	Grease Trap	2004	1,903						58
59	Quarry Tile	2004	3,165						59
60	Parking Lot Sealcoat	2004	1,579						60
61	HVAC unit	2004	1,000						61
62	Sprinkler Leak	2004	1,854						62
63	Hot Water Boiler	2004	2,133						63
64	Corridor Remodel Material and Labor	2004	20,242						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,254,185	\$ 86,943		\$ 74,256	\$ (12,687)	\$	70

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

Facility Name & ID Number Heritage Health-Gibson City

0048116

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,254,185	\$ 86,943		\$ 74,256	\$ (12,687)	\$	1
2	Oxygen Room	2005	2,005						2
3	Heat/Cool Unit	2005	17,228						3
4									4
5	Heat/Cool Units	2006	25,182						5
6	Door	2006	2,887						6
7	Heater	2006	1,078						7
8	Sidewalk	2006	3,500						8
9	Boiler	2006	1,427						9
10	Remodel TLC Unit --carpet, paint,	2006	27,516						10
11	Parking Lot sealer	2006	1,699						11
12	Drapes	2006	1,172						12
13	adjustments	2006	(7,711)						13
14	dishwasher motor	2007							14
15	Remodel TLC Unit --carpet, paint,	2007	2,996						15
16	Water Heater	2007	2,907						16
17	Grease Trap	2007							17
18	Water Softener	2007	12,285						18
19									19
20	Emergency Alarms	2008	36,893						20
21									21
22	Water Heater	2008	4,982						22
23	Exterior Painting	2008	9,720						23
24									24
25	Sprinkler System	2009	11,980						25
26	Water Heater	2009	4,503						26
27	Generator	2009	26,450						27
28									28
29	Water Heater	2010	3,750						29
30	Generator	2010	43,596						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,490,230	\$ 86,943		\$ 74,256	\$ (12,687)	\$	34

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

Facility Name & ID Number Heritage Health-Gibson City

0048116

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,490,230	\$ 86,943		\$ 74,256	\$ (12,687)	\$	1
2									2
3	Micromatic Scrubber	2011	3,932						3
4	Duro-Last Roofing	2001	9,600						4
5	Trane Rooftop Unit	2001	23,888						5
6									6
7	Water Heater	2012	3,808						7
8	Lighting Retrofit	2012	6,719						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)		\$ 2,538,177	\$ 86,943		\$ 74,256	\$ (12,687)	\$	34

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

Facility Name & ID Number Heritage Health-Gibson City

0048116

Report Period Beginning:

01/01/12

Ending:

12/31/12

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		\$ 2,538,177	\$ 86,943		\$ 74,256	\$ (12,687)	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$ 2,538,177	\$ 86,943		\$ 74,256	\$ (12,687)	\$

**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	\$ 535,274	\$ 20,559	\$ 20,559	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 535,274	\$ 20,559	\$ 20,559	\$		\$	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,093,451	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 107,502	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 94,815	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (12,687)	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: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

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

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. _____ /2013 \$ _____

13. _____ /2014 \$ _____

14. _____ /2015 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
 by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 32,466 Description: _____

(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.

Facility Name & ID Number Heritage Health-Gibson City # 0048116 Report Period Beginning: 01/01/12 Ending: 12/31/12
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.)

	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	\$		\$ 112,968	\$		\$ 112,968	1
2	Licensed Speech and Language Development Therapist		hrs			5,293			5,293	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			104,017	725		104,742	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				208,032		208,032	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					32,586			32,586	13
14	TOTAL			\$		\$ 254,864	\$ 208,757		\$ 463,621	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-Gibson City

0048116

Report Period Beginning: 01/01/12

Ending:

12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12 (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	\$ 2,634	\$	1
2	Cash-Patient Deposits	6,006		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	721,973		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,238		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(2,004,253)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (1,257,402)	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (1,257,402)	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 134,776	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,006		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	161,255		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,130		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	<u>Assessment Tax</u>	89,338		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 393,505	\$	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)	\$ 393,505	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,650,907)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (1,257,402)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,226,228)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,226,228)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(424,679)	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)	\$ (424,679)	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)	\$ (1,650,907)	24 *

* This must agree with page 17, line 47.

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	\$ 2,913,398		1
2	Discounts and Allowances for all Levels	(849,018)		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,064,380		3
B. Ancillary Revenue				
4	Day Care			4
5	Other Care for Outpatients			5
6	Therapy	771,066		6
7	Oxygen			7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 771,066		8
C. Other Operating Revenue				
9	Payments for Education			9
10	Other Government Grants			10
11	CNA Training Reimbursements			11
12	Gift and Coffee Shop	363		12
13	Barber and Beauty Care	5,469		13
14	Non-Patient Meals			14
15	Telephone, Television and Radio			15
16	Rental of Facility Space			16
17	Sale of Drugs	377,633		17
18	Sale of Supplies to Non-Patients			18
19	Laboratory			19
20	Radiology and X-Ray			20
21	Other Medical Services			21
22	Laundry			22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 383,465		23
D. Non-Operating Revenue				
24	Contributions			24
25	Interest and Other Investment Income***	2,979		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,979		26
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)			27
28		(4,192)		28
28a				28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (4,192)		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,217,698		30

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	631,884		31
32	Health Care	1,768,990		32
33	General Administration	858,711		33
B. Capital Expense				
34	Ownership	379,187		34
C. Ancillary Expense				
35	Special Cost Centers	3,605		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)*	\$ 3,642,377		40
41	Income before Income Taxes (line 30 minus line 40)**	(424,679)		41
42	Income Taxes			42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (424,679)		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.

Facility Name & ID Number Heritage Health-Gibson City

0048116

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	1,904	2,032	\$ 63,285	\$ 31.14	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	10,574	11,214	319,569	28.50	3
4	Licensed Practical Nurses	6,678	6,993	166,847	23.86	4
5	CNAs & Orderlies	39,524	42,955	555,846	12.94	5
6	CNA Trainees		0			6
7	Licensed Therapist					7
8	Rehab/Therapy Aides		0			8
9	Activity Director					9
10	Activity Assistants	3,430	3,430	47,808	13.94	10
11	Social Service Workers	1,916	2,060	34,121	16.56	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,206	16,063	186,268	11.60	15
16	Dishwashers					16
17	Maintenance Workers	3,897	4,275	46,770	10.94	17
18	Housekeepers	5,718	6,111	64,520	10.56	18
19	Laundry	3,226	3,415	47,269	13.84	19
20	Administrator	1,950	2,080	74,370	35.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,972	6,512	124,377	19.10	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)	99,995	107,140	\$ 1,731,050 *	\$ 16.16	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 0		35
36	Medical Director	10,800		36
37	Medical Records Consultant	1,930		37
38	Nurse Consultant			38
39	Pharmacist Consultant	4,500		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	3,010		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 20,240		49

C. CONTRACT NURSES

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

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Heritage Health-Gibson City# 0048116Report Period Beginning: 01/01/12Ending: 12/31/12**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. Illinois Health Care Association
- (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 years
- (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? _____
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x 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. \$ 41,175
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? yes 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. \$ 8,233
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? _____
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? _____ If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
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? yes
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Sulaski & Webb
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number	Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg Adjustment Line #	Amount
1009	PETTY CASH	2,634				1,009	1,009 PETTY C 2,634
1010	CASH IN BANK					1,100	1,100 ACCTS R 721,973
1040	CASH IN BANK-PAYROLL					1,101	1,101 ALLOW. FOR UNCOLLECTIBI
1100	ACCOUNTS RECEIVABLE	721,973				1,110	1,110 ACCTS RECEIV-M/C
1110	MEDICARE RECEIVABLES					1,125	1,125 ACCTS RECEIV-IPA
1125	IPA INCOME RECEIVABLE					1,135	1,135 ACCTS RECEIV-IC
1130	MEDICARE COST REPORT					1,140	1,140 UNAPPLIED CASH RECEIPTS
1135	ACCOUNTS RECEIVABLE-IC					1,145	1,145 A/R SUSPENSE-REFUNDS
1140	UNAPPLIED CASH RECEIPTS					1,200	1,200 PREPAID 16,238
1145	A/R SUSPENSE-REFUNDS					1,220	1,220 OTHER PREPAID EXPENSES
1190	ACCRUED INTEREST REC					1,300	1,300 DIETARY INVENTORY
1200	PREPAID INSURANCE	16,238				1,310	1,310 SUPPLIES INVENTORY
1220	OTHER PREPAID EXPENSES					1,320	1,320 LINEN INVENTORY
1300	FOOD INVENTORY					1,409	1,409 LAND 0
1310	SUPPLIES INVENTORY					1,450	1,450 FURNITU 0
1409	LAND	0				1,460	0
1450	FURNITURE & EQUIPMENT	0				1,475	1,475 CODE AI 0
1460	ACCUM DEPR-FURN & EQU	0				1,490	1,490 ACCUM] 0
1475	BUILDING & IMPROVEMEN	0				1,530	1,530 RESIDEN 6,006
1490	ACCUM DEPR-BUILDING	0				1,550	1,550 LOAN FE 0
1530	RESIDENT FUNDS	6,006				1,551	1,551 LOAN FEES ADDED
1550	LOAN FEES	0				1,850	1,850 INTERCC (2,004,253)
1560	REAL ESTATE TAX ESCROW					2,010	2,010 ACCOUN (134,776)
1575	REIMBURSABLE PURCHASES					2,100	2,095 BONUSES PAYABLE
1850	INTRACOMPANY	-2,004,253				2,100	2,100 ACCRUE (47,815)
2010	ACCOUNTS PAYABLE	-134,776				2,100	2,100 PR CLEARING-BENEFITS
2095	BONUSES PAYABLE					2,100	2,100 PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-47,815				2,110	2,110 ACCRUE (113,440)
2110	ACCRUED VACATION PAY	-113,440				2,120	2,120 U.C. TAXES PAYABLE

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	(2,130)
2125	FICA TAX PAYABLE	-2,130	-2,130	2,130	2,130 FEDERAL W/H TAX PAYABLE	
2130	FIT PAYABLE			2,140	2,140 STATE W/H TAX PAYABLE	
2140	STATE W/H PAYABLE		0	2,152	2,152 WORKERS COMP ACCRUAL	
2145	EARNED INCOME CREDIT			2,225	2,225 EMPLOYEE INSURANCE RE	
2150	UC FED CREDIT REDUCTION			2,230	2,230 PAYROLL SAVINGS	
2230	PAYROLL SAVINGS			2,235	2,240 UNITED FUND	
2235	IRA W/HOLDINGS			2,240	2,246 GROUP INSURANCE - CAFETERIA	
2240	UNITED WAY			2,246	2,250 401K W/H	
2245	GROUP INSURANCE PAYABLE			2,250		
2246	GROUP INSURANCE PAYABLE-CAFETERIA			2,260	2,260 WAGE GARNISHMENT	
2260	WAGE GARNISHMENTS			2,300	2,300 ACCRUE	0
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYI	(89,338)
2300	ACCRUED INTEREST PAYA	0		2,350	2,350 REAL ES	0
2310	SALES TAX PAYABLE			2,385		0
2320	IPA PAYMENTS PAYABLE	-89,338		2,400	2,400 CURRENT PORTION OF LT DE	
2350	REAL ESTATE TAX PAYAB	0		2,512	2,512 DUE TO I	(6,006)
2385	ACTIVITY FUND	0		2,600	2,600 LASALLE	0
2390	SECURITY DEPOSITS	0		2,600		
2391	VOLUNTEER FUND			2,625	2,625 LASALLE CONSTR. LOAN #2	
2393	HEART FUND/BAZAAR			2,625		
2395	DEFERRED INC EMP & MEM			2,695	2,695 CURRENT PORTION OF LT DE	
2400	CURRENT PORTION LT DEBT			2,720	2,720 RETAINED	1,226,228
2460	INCOME TAXES PAYABLE				net income	424,679
2512	DUE TO RESIDENTS	-6,006				
2600	MORTGAGE PAYABLE	0				
2650	EQUIPMENT LOAN PAYABLE				balance	<u>0</u>
2695	CURRENT PORTION LT DEBT					
2696	DEFERRED INCOME TAXES					
2710	COMMON STOCK					
2720	RETAINED EARNINGS	1,226,228				
2970	PROFIT/LOSS FOR PERIOD	424,679				
3007.1	PATIENT DAYS-PRIVATE	4,851				

3,007

3007.2	PATIENT DAYS-IPA	14,588						3,007
3007.3	PATIENT DAYS-MEDICARE	1,411						3,007
3007.4	PATIENT DAYS-CONVERSION							3,007
3007.5	PATIENT DAYS-LICENSED							3,007
3007.6	PATIENT DAYS-TOTAL							3,007
3010	1 BASIC CHARGE-PRIVATE &	-2,864,587	0	0	0	0		3,007
3015	1 PRIVATE ASSESSMENT TAX INCOME		0	0	0	0		3,010
3020	1 BASIC CHARGE-IPA	0	0	0	0	0		3,020
3030	1 BASIC CHARGE-MEDICARI	0	0	0	0	0		3,030
3035	4 DAY CARE/HOME CARE		0	0	0	0		3,040
3040	1 LIGHT NURSING CARE	0	0	0	0	0		3,050
3050	1 MEDIUM NURSING CARE		0	0	0	0		3,060
3060	1 HEAVY NURSING CARE		0	0	0	0		3,061
3061	1 SKILLED NURSING CARE							3,080
3080	1 NURSING SUPPLIES-PRIVA	-48,811	0	0	0	0		3,081
3081	1 NURSING SUPPLIES-IPA		0	0	0	0		3,082
3082	1 NURSING SUPPLIES MED PT A		0	0	0	0		3,083
3083	1 NURSING SUPPLIES MED PT B							3,100
3100	17 DRUGS	-377,633	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-771,066	0	0	0	0		3,111
3111	6 PT-IPA		0	0	0	0		3,112
3112	6 PT-MEDICARE PART A		0	0	0	0		3,113
3113	6 PT-MEDICARE PART B		0	0	0	0		3,140
3130	1 PUBLIC AID ASSESSMENT INC							3,150
3140	19 LABORATORY INCOME		0	0	0	0		3,151
3150	6 SPEECH/OT-PRIVATE		0	0	0	0		3,152
3151	6 SPEECH/OT-IPA		0	0	0	0		3,153
3152	6 SPEECH/OT-MED PART A		0	0	0	0		3,160
3153	6 SPEECH/OT MED PART B							3,410
3410	2 IPA DISCOUNTS	849,018	0	0	0	0		3,411
3411	2 MEDICAID PART B DISCOUNT		0	0	0	0		3,420
3420	2 MEDICARE DISCOUNTS		0	0	0	0		3,500

3440	36 ASSESSMENT TAX EXPENSE			42	3	0	0		3,520
3520	16 RENT INCOME	0		6	0	6	0		3,530
3530	13 BEAUTY SHOP	-5,469		0	0	0	0		3,560
3560	12 ACTIVITY FUND INCOME	-390		0	0	0	0		3,570
3570	12 VENDING INCOME/EXPENSE	27		0	0	0	0		3,590
3580	12 MANAGEMENT FEES			0	0	0	0		3,595
3590	1 EQUIPMENT RENTAL	0		0	0	0	0		3,600
3595	21 RESIDENT TRANSPORTATION	0		0	0	0	0		4,110
3600	21 MISC INCOME	0		0	0	0	0		4,111
4110	GENERAL & ADMINISTRATIVE WAGES	114,544	124,377	21	1	17	0		4,115
4111	ADMINISTRATOR WAGES	74,370	74,370	17	1	0	0		4,120
4115	VACATION & SICK - G&A	9,833		21	1	0	0		4,125
4120 4475	EMPLOYEE BENEFITS	5,948	384,917	22	3	0	0		4,130
4125	EMPLOYEE HOLIDAY VACATION	0		22	3	0	0		4,135
4130	EMPLOYEE SCHOLARSHIP	0		21	1	0	0		4,250
4135	EMPLOYEE SCHOLARSHIP	0		23	3	0	0		4,255
4220	DIRECTORS FEES	0	0	18	3	0	0		4,260
4250 4255	OFFICE SUPPLIES	17,439	17,439	21	2	0	0		4,275
4260	TELEPHONE	10,605	10,605	21	3	0	0		4,276
4275	TRAINING & EMPLOYEE DEVELOPMENT	2,427	2,427	23	3	16	-428 **		4,280
4280	GENERAL TRAVEL	3,325	3,725	24	3	16	0		4,281
4281	MEAL EXPENSE FOR TRAVEL	35		24	3	19	0		4,285
4285	EDUCATION & SEMINAR	365		24	3	19	-4,538 ***		4,289
4290	HELP WANTED ADVERTISING	1,446	53,672	20	3	0	0	-41,175	4,290
4291	PROMOTIONAL ADVERTISING	2,060		20	3	25	-2,060		4,291
4292	PUBLIC RELATIONS	2,535		20	3	25	-2,535		4,292
4300	LICENSES & FEES	41,800		20	3	17	0		4,300
4310	DUES & SUBSCRIPTIONS	4,801		20	3	17	-360		4,310
4320	CONTRIBUTIONS	100		27	3	20	0		4,320
4350	PROFESSIONAL FEES	2,124	145,473	19	3	22	-2,124		4,350
4355	MEDICAL DIRECTOR	10,800	10,800	9	3	0	0		4,355
4360	UTILIZATION REVIEW	0		10	3	0	0		4,362
4361	OTHER PHYSICIAN FEES			39	3	0	0		4,363

4362	MEDICAL RECORDS CONSI	1,930		10	3	0	0	4,364
4363	PHARMACIST FEES	4,500		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	3,010	3,010	12	3	0	0	4,383
4370	TV RENTAL	4,399		35	3	5	0	4,390
4380	INCOME TAXES		1,280	27	3	26	0	4,400
4383	BACKGROUND CHECKS	1,030		20	3	26	0	4,401
4400	PAYROLL TAXES	156,273		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	7,517		22	3	0	0	4,420
4410	GROUP INSURANCE	180,217		22	3	0	0	4,430
4420	LIABILITY INSURANCE	40,426	40,426	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSUR/	34,962		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	143,349		19	3	34	0 **	4,460
4460	BAD DEBTS	1,180		27	3	24	-1,180	4,461
4470	LOST ITEMS-RESIDENTS	0		27	3	0		4,470
4490	MISCELLANEOUS	0		27	3	0	0	4,475
4510	REAL ESTATE TAXES	0	0	33	3	0	0	4,486
4600	LEASED EQUIPMENT	28,067	32,466	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	45,148	46,770	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	1,622		6	1	0	0	4,510
5130	ELECTRIC	26,017	50,144	5	3	0	0	4,600
5131	NATURAL GAS	15,582		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	8,545		5	3	0	0	5,130
5134	TRASH COLLECTION	4,055	37,396	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	15,099	29,673	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN'	14,574		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC'	33,341		6	3	0	0	5,140
5210	DIETARY WAGES	175,773	186,268	1	1	0	0	5,160
5220	DIETARY SICK & VAC	10,495		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	148,905	140,672	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	2,048	6,672	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	714		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	3,910		1	2	0	0	5,260
5295	MEAL CREDIT	-8,233		2	2	0	0	5,270
5310	LAUNDRY WAGES	45,239	47,269	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	2,030		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	3,903	7,555	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	3,652		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	61,804	64,520	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	2,716		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	10,193	14,945	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	4,752		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,105,547	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	301,544		10	1	0	0	6,020
6030	DON WAGES	63,285		10	1	0	0	6,030
6035	ADON	0		10	1	0	0	6,035
6040	RN SICK & VACATION	18,025		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	160,886		10	1	0	0	6,120
6120	LPN WAGES-NON MEDICAL	0		10	1	0	0	6,140
6130	LPN WAGES OTHER			10	1	0	0	6,220
6140	LPN SICK & VACATION	5,961		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICAL	530,308		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	25,538		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	0		10	3	0	0	6,255
6246	CONTRACT NURSES-LPN	0		10	3	0	0	6,260
6247	CONTRACT NURSES-AIDES	0		10	3	0	0	6,270
6250	NURSE AIDE TRAINING W/	0	0	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	0	0	13	2	0	0	6,290
6260	NURSE AIDE TRAINING RE	0		0	0	0	0	6,295
6270	REHAB WAGES	0		10	1	0	0	6,390
6275	REHAB SICK & VAC	0		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	57,979	95,546	10	2	0	0	7,281
6295	NURSING SUPPLIES	29,586		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	7,981		10	2	0	0	7,391
6490	NURSING OTHER	555	6,985	10	3	0	0	7,393
7280	DRUG PURCHASES	81,508	208,757	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	126,524		39	2			7,540
7380	LABORATORY SERVICES	32,586	254,864	39	3	0	0	7,590
7410	HOME HEALTH SALARY			39	1	0	0	7,620
7440	HOME HEALTH SICK & VAC			39	1	0	0	7,660
7450	HOME HEALTH EXPENSES			39	3	0	0	7,710
7510	ACTIVITES WAGES	44,779	47,808	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	3,029		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	1,552	1,552	11	2	0	0	7,740
7595	ACTIVITIES FEES	0	0	11	3	0	0	7,750
7610	PT WAGES			39	1	0	0	7,770
7611	PT SICK & VACATION			39	1	0	0	7,820
7620	PT FEES	104,017		39	3	0	0 ***	7,890
7660	PT SUPPLIES	725		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	31,531	34,121	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	2,590		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0	8,130
7740	OT FEE	112,968		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	5,293		39	3	0	0 ***	9,520
7800	BEAUTICIAN WAGES		0	40	1	0	0	9,530
7810	BEAUTICIAN SICK & VAC			40	1	0	0	
7820	BEAUTICIAN FEES	3,605	3,605	40	3	0	0	
7890	BEAUTY SHOP SUPPLIES	0	0	40	2	0	0	
7910	VOLUNTEER COORDINATOR			21	1	0	0	
7940	VOL COORD SICK & VAC			21	1	0	0	
7960	VOL COORD SUPPLIES	0		21	2	0	0	
8100	RENT	328,500	328,500	34	3	0	0	

8120	INTEREST EXPENSE	18,221	18,221	32	3	14	-2,979	
8130	DEPRECIATION	0	0	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	60,773
9510	INTEREST INCOME	-2,979		32	0	10	0	
9520	MISC NON-OPERATING INC	0		0	0	0	0	
9700	INCOME TAXES	4,192		0	0	0	0	
		3,643,590	3,642,377					
			-1,213					

GRAND TOTALS 424,679 -16,204
(NET INCOME)

0

FACILITY NAME:

FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

G/L

RECAP CENSUS

PP	4,851	4,851
IPA	14,588	14,588
medicare	1,411	1,411
		20,850

IPA BEDHOLDS 0

PP BEDHOLDS 0

PP CONVERS 0

LES

3

FUND

ERIA

EBT

EBT

3,007 PATIENT	14,588
3,007 PATIENT	1,411
	0

3,010 BASIC CI (2,864,587)

3,020 BASIC CI 0

3,030 BASIC CI 0

0

0

0

0

3,080 NURSING (48,811)

3,081 NURSING 0

3,082 NURSING 0

3,083 NURSING 0

3,100 DRUGS-M (377,633)

0

3,110 PHYSICIAN (771,066)

0

3,112 PHYSICIAN 0

3,113 PHYSICIAN 0

3,140 LABORATORY INCOME

0

3,152 ST/OT TR 0

3,153 ST/OT TR 0

3,185 REHABILITATION/ISOLATION/OTHER CHG

3,410 IPA/OTHER 0

3,411 MEDICAL 0

3,420 MEDICAL 811,153

3,520 RENT INC	0
3,530 BEAUTY	(5,469)
	(390)
3,570 VENDING	27
3,590 EQUIPMI	0
3,595 RESIDEN	0
3,600 MISC INC	0
4,110 G&A WA	114,544
4,111 ADMINIS	74,370
4,115 G&A PTC	9,833
4,120 EMPLOY	8,019
	0
4,130 EMPLOY	0
4,135 EMPLOYEE SCHOLARSHIPS-COSTS	
4,250 OFFICE S	7,260
4,255 POSTAGI	944
4,260 TELEPHC	10,605
4,275 TRAININ	2,427
	15
4,280 GENERA	3,325
4,281 MEAL EX	35
4,285 EDUCAT	365
4,289 MEETING	0
4,290 HELP WA	1,446
4,291 PROMOT	2,060
4,292 PUBLIC I	2,535
4,300 LICENSE	41,800
4,310 DUES & F	4,801
4,320 CONTRIB	100
4,350 PROFESS	2,124
4,355 MEDICAL	10,800
	1,930
	4,500

4,364 SOCIAL S	3,010
4,370 TV RENT	4,399
4,383 BACKGR	1,030
4,390 OTHER T	4,192
4,400 PAYROL	156,273
4,401 PAYROL	7,517
4,410 GROUP I	180,217
4,420 LIABILIT	40,426
4,430 WORKM.	33,802
4,435 W/C-FIRS	625
4,436 DRUG TE	520
4,450 MANAGI	143,349
4,460 BAD DEF	1,180
4,461 BAD DEF	37,865
4,470 LOST ITE	0
4,475 UNIFORM	(2,071)
4,486 SERVICE	15,003
4,490 MISC EX	82
4,496 MISC. M.	9,235
4,510 REAL ES	0
4,600 LEASED	28,067
5,110 MAINTEI	45,148
5,120 MAINTEI	1,622
5,130 ELECTRI	26,017
5,131 NATURA	15,582
5,133 WATER &	8,545
5,134 TRASH C	4,055
5,140 PROP/PL	15,099
5,160 GENERA	14,574
5,165 MAINTEI	18,338
5,210 DIETARY	175,773
5,220 DIETARY	10,495
5,248 FOOD PU	148,823

5,250 SUPPLIE	2,048
5,260 REPLACI	714
5,270 KITCHEN	3,910
5,295 MEAL IN	(8,233)
5,310 LAUNDR	45,239
5,340 LAUNDR	2,030
5,370 REPLACI	3,903
	0
5,390 SUPPLIE	3,652
5,410 HOUSEK	61,804
5,440 HOUSEK	2,716
5,480 SUPPLIE	10,193
5,490 SUPPLIE	4,752
6,020 RN WAG	301,544
6,030 DON WA	63,285
6,035 ADON W	0
6,040 RN PTO &	18,025
6,120 LPN WAG	160,886
6,140 LPN PTO	5,961
6,220 AIDES W	530,308
6,240 AIDES PT	25,538
	0
	0
	0
	0
6,270 REHAB V	0
6,275 REHAB F	0
6,290 NURSINC	57,979
6,295 NURSINC	29,586
6,390 REPLACI	7,981
6,490 OTHER	555

7,280 DRUG PU	81,508
7,281 DRUG PU	126,524
7,380 LABORA	1,737
7,390 X-RAY S	16,491
	14,358
7,510 ACTIVIT	44,779
7,540 ACTIVIT	3,029
7,590 ACTIVIT	1,552
7,620 PHYSICA	104,017
7,660 P.T. SUPE	725
7,710 SOCIAL S	31,531
7,720 SOCIAL S	2,590
7,730 SOCIAL S	0
7,740 OCCUPA	112,968
	0
7,770 SPEECH '	5,293
7,820 BEAUTIC	3,605
	0
	0
8,120 INTERES	0
	18,221
8,130 DEPRECI	0
	0
9,510 INTERES	(2,979)
9,520 MISC NO	0
4,220	0
8,100	328,500
9,702	0
5,230	0
	<u>424,679</u>

Expenses Fixed Assets

Related Parties
From Page 6

FACILITY	MEDICAID NUMBER	STATE LICENSE NUMBER
Owned SNFs		
Heritage Health - South, IL	20-5300302001	48843
Heritage Health - Blooming	20-3904134001	48157
Heritage Health - Carlinville	20-5508113001	48850
Heritage Health - Chillicothe	20-5412664001	48868
Heritage Health - Dwight, IL	20-5412784001	50492
Heritage Health - Elgin, IL	20-3902154001	48132
Heritage Health - El Paso, IL	20-3903447001	48124
Heritage Health - Gibson City	20-3902572001	48116
Heritage Health - Gillespie	20-5428620001	48892
Heritage Health - LaSalle, IL	27-3741988001	51276
Heritage Health - Litchfield	20-5508096001	48900
Heritage Health - Mendota	20-3904038001	48108
Heritage Health - Minonk, IL	20-3903980001	48058
Heritage Health - Mt. Sterling	20-3903543001	48041
Heritage Health - Mt. Zion	20-3903622001	48074
Heritage Health - Normal, IL	20-3903883001	48082
Heritage Health - Pana, IL	20-5508128001	48884
Heritage Health - Peru, IL	20-3902978001	48090
Heritage Health - Staunton	20-5437628001	48876
Heritage Health - Streator	20-3902216001	48066
Barton W. Stone Jackson	20-5298969002	48918
Danville Joint Ventures, IL	37-1357323001	42168
Heritage Health	37-1359387001	41699
Cotillion Ridge	37-1402726001	45138
Country Health	37-6064916001	7880
Mason City	37-1168043001	34256
St. Clara's Medical	37-6075710001	50724
Vonderlieth	37-0967671001	19976