FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0048058

Facility Name: Heritage Health-Minonk

Address: 201 Locust St (Number) Minonk (City) 61760 (Zip Code)

County: Woodford

Telephone Number: (309) 432-2557 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: 07/2006

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		x	Limited Liability Co.		
			Trust		
			Other		

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Craig Ater

(Title) Exec VP & CFO

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) Fax # ( )

In the event there are further questions about this report, please contact:
Name: Craig Ater Telephone Number: (309) 823-7135
Email Address:

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Heritage Health-Minonk # 0048058 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	49	Skilled (SNF)	49	17,934	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	23	Sheltered Care (SC)	23	8,418	5
6		ICF/DD 16 or Less			6
7	72	TOTALS	72	26,352	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,073	5,017	1,646	13,736	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		3,225		3,225	12
13	DD 16 OR LESS					13
14	TOTALS	7,073	8,242	1,646	16,961	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.36%

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 [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 07/2006

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified _____ and days of care provided 1,646

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [x] 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-Minonk # 0048058 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 Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	162,915	6,348		169,263		169,263	4,462	173,725			1
2	Food Purchase		123,873		123,873		123,873	33	123,906			2
3	Housekeeping	54,662	22,408		77,070		77,070		77,070			3
4	Laundry	31,839	8,115		39,954		39,954		39,954			4
5	Heat and Other Utilities			64,169	64,169		64,169	1,064	65,233			5
6	Maintenance	73,569	57,773	32,238	163,580		163,580	10,986	174,566			6
7	Other (specify):*											7
8	**TOTAL General Services**	322,985	218,517	96,407	637,909		637,909	16,545	654,454			8
	B. Health Care and Programs											
9	Medical Director			747	747		747	1,869	2,616			9
10	Nursing and Medical Records	864,623	54,987	7,032	926,642		926,642	1	926,643			10
10a	Therapy		188,419	286,680	475,099	(207,478)	267,621	9,017	276,638			10a
11	Activities	61,945	5,241		67,186		67,186		67,186			11
12	Social Services	35,081		1,702	36,783		36,783		36,783			12
13	CNA Training	3,406	120		3,526		3,526	745	4,271			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	965,055	248,767	296,161	1,509,983	(207,478)	1,302,505	11,632	1,314,137			16
	C. General Administration											
17	Administrative	78,162			78,162		78,162		78,162			17
18	Directors Fees											18
19	Professional Services			138,413	138,413		138,413	(126,594)	11,819			19
20	Dues, Fees, Subscriptions & Promotions			59,143	59,143	(26,901)	32,242	(15,758)	16,484			20
21	Clerical & General Office Expenses	107,077	14,614	5,168	126,859		126,859	202,689	329,548			21
22	Employee Benefits & Payroll Taxes			275,819	275,819		275,819	28,776	304,595			22
23	Inservice Training & Education			2,545	2,545		2,545	(546)	1,999			23
24	Travel and Seminar			8,818	8,818		8,818	(6,819)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			30,569	30,569		30,569	7,844	38,413			26
27	Other (specify):*			40,000	40,000		40,000	(40,000)				27
28	**TOTAL General Administration**	185,239	14,614	560,475	760,328	(26,901)	733,427	49,592	783,019			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,473,279	481,898	953,043	2,908,220	(234,379)	2,673,841	77,769	2,751,610			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-Minonk #0048058 Report Period Beginning: 01/01/12 Ending: 12/31/12

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							190,716	190,716			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,920	11,920		11,920	47,694	59,614			32
33	Real Estate Taxes							31,287	31,287			33
34	Rent-Facility & Grounds			315,360	315,360		315,360	(310,805)	4,555			34
35	Rent-Equipment & Vehicles			10,219	10,219		10,219	703	10,922			35
36	Other (specify):*											36
37	TOTAL Ownership			337,499	337,499		337,499	(40,405)	297,094			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					207,478	207,478		207,478			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					26,901	26,901		26,901			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers					234,379	234,379		234,379			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,473,279	481,898	1,290,542	3,245,719		3,245,719	37,364	3,283,083			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-Minonk # 0048058 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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(586)			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)	(546)			16
17	Non-Care Related Fees	(446)			17
18	Fines and Penalties				18
19	Entertainment	(9,518)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,892)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(40,000)			24
25	Fund Raising, Advertising and Promotional	(20,694)			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)**	$ (75,682)		$	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)	113,046		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 113,046		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 37,364		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Heritage Health-Minonk

ID# 0048058

Report Period Beginning: 01/01/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line 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		(446)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(3,892)	19	22
23				23
24		(40,000)	27	24
25		(20,694)	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**	(65,032)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health-Minonk # 0048058 **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 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)	
	A. General Services													
1	Dietary	0	0	4,462	0	0	0	0	0	0	0	0	4,462	1
2	Food Purchase	0	0	33	0	0	0	0	0	0	0	0	33	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	1,064	0	0	0	0	0	0	0	0	1,064	5
6	Maintenance	0	0	10,986	0	0	0	0	0	0	0	0	10,986	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	16,545	0	0	0	0	0	0	0	0	16,545	8
	B. Health Care and Programs													
9	Medical Director	0	0	1,869	0	0	0	0	0	0	0	0	1,869	9
10	Nursing and Medical Records	0	0	1	0	0	0	0	0	0	0	0	1	10
10a	Therapy	0	9,017	0	0	0	0	0	0	0	0	0	9,017	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	745	0	0	0	0	0	0	0	0	745	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	9,017	2,615	0	0	0	0	0	0	0	0	11,632	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	(3,892)	(134,521)	11,819	0	0	0	0	0	0	0	0	(126,594)	19
20	Fees, Subscriptions & Promotions	(21,140)	0	5,382	0	0	0	0	0	0	0	0	(15,758)	20
21	Clerical & General Office Expenses	0	0	202,689	0	0	0	0	0	0	0	0	202,689	21
22	Employee Benefits & Payroll Taxes	0	0	28,776	0	0	0	0	0	0	0	0	28,776	22
23	Inservice Training & Education	(546)	0	0	0	0	0	0	0	0	0	0	(546)	23
24	Travel and Seminar	(9,518)	0	2,699	0	0	0	0	0	0	0	0	(6,819)	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	7,844	0	0	0	0	0	0	0	0	7,844	26
27	Other (specify):*	(40,000)	0	0	0	0	0	0	0	0	0	0	(40,000)	27
28	**TOTAL General Administration**	(75,096)	(134,521)	259,209	0	0	0	0	0	0	0	0	49,592	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(75,096)	(125,504)	278,369	0	0	0	0	0	0	0	0	77,769	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health-Minonk # 0048058 **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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	178,536	0	12,180	0	0	0	0	0	0	0	190,716	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(586)	48,000	0	280	0	0	0	0	0	0	0	47,694	32
33	Real Estate Taxes	0	31,256	0	31	0	0	0	0	0	0	0	31,287	33
34	Rent-Facility & Grounds	0	(315,360)	0	4,555	0	0	0	0	0	0	0	(310,805)	34
35	Rent-Equipment & Vehicles	0	0	0	703	0	0	0	0	0	0	0	703	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(586)	(57,568)	0	17,749	0	0	0	0	0	0	0	(40,405)	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)	(75,682)	(183,072)	278,369	17,749	0	0	0	0	0	0	0	37,364	45

Facility Name & ID Number Heritage Health-Minonk # 0048058 Report Period Beginning: 01/01/12 Ending: 12/31/12

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Heritage Enterprises, Inc.	100	See Pg 25				

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	10a	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	9,017	9,017	2
3	V								3
4	V	19	Adjustment for Related Organization	134,521	Heritage Operations Group, LLC	0.00%		(134,521)	4
5	V								5
6	V	34	Adjustment for Related Organization	315,360	Heritage Manor Real Estate, LLC	0.00%		(315,360)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		31,256	31,256	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		43,227	43,227	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		178,536	178,536	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		4,773	4,773	10
11	V								11
12	V								12
13	V								13
14	Total			$ 449,881			$ 266,809	$ * (183,072)	14

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

Facility Name & ID Number Heritage Health-Minonk # 0048058 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Heritage Enterprises, Inc.		$	$ 4,462	15
16	V	2	Food Purchase					33	16
17	V	3	Housekeeping					0	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,064	19
20	V	6	Maintenance					10,986	20
21	V	7	Other					0	21
22	V	9	Medical Director					1,869	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					745	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					11,819	31
32	V	20	Fees, Subscription, Promotions					5,382	32
33	V	21	Clerical & General Office Expenses					202,689	33
34	V	22	Employee Benefits & Payroll Taxes					28,776	34
35	V	23	Inservice Training & Education					0	35
36	V	24	Travel and Seminar					2,699	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					7,844	38
39	Total			$			$ 0	$ * 278,369	39

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

Facility Name & ID Number Heritage Health-Minonk # 0048058 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	$	Heritage Enterprises, Inc.		$	$ 0	15
16	V	30	Depreciation					12,180	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					280	18
19	V	33	Real Estate Taxes					31	19
20	V	34	Rent-Facility & Grounds					4,555	20
21	V	35	Rent-Equipment & Vehicles					703	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								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ * 17,749	39

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

Facility Name & ID Number Heritage Health-Minonk # 0048058 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-Minonk # 0048058 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	
	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	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-Minonk # 0048058 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 [x] NO [ ]

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

Name of Related Organization: Heritage Operations Group
Street Address: box 3188
City / State / Zip Code: Bloomington, Il 61701
Phone Number: ( )
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	Dietary	Beds	2,735	26	$ 169,500	$ 168,827	72	$ 4,462	1
2	2	Food Purchase	Beds	2,735	26	1,241	0	72	33	2
3	3	Housekeeping	Beds	2,735	26	0	0	72	0	3
4	4	Laundry	Beds	2,735	26	0	0	72	0	4
5	5	Heat & Other Utilities	Beds	2,735	26	40,426	0	72	1,064	5
6	6	Maintenance	Beds	2,735	26	417,328	78,403	72	10,986	6
7	7	Other	Beds	2,735	26	0	0	72	0	7
8	9	Medical Director	Beds	2,735	26	71,007	0	72	1,869	8
9	10	Nursing & Medical Records	Beds	2,735	26	33	70,119	72	1	9
10	11	Activities	Beds	2,735	26	0	0	72	0	10
11	12	Social Service	Beds	2,735	26	0	0	72	0	11
12	13	Nurse Aide Training	Beds	2,735	26	28,290	22,496	72	745	12
13	14	Program Transportation	Beds	2,735	26	0	0	72	0	13
14	15	Other	Beds	2,735	26	0	0	72	0	14
15	17	Administrative	Beds	2,735	26	0	0	72	0	15
16	18	Directors Fees	Beds	2,735	26	0	0	72	0	16
17	19	Professional Services	Beds	2,735	26	448,954	0	72	11,819	17
18	20	Fees, Subscription, Promotions	Beds	2,735	26	204,427	0	72	5,382	18
19	21	Clerical & General Office Expens	Beds	2,735	26	7,699,360	7,229,609	72	202,689	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,735	26	1,093,087	0	72	28,776	20
21	23	Inservice Training & Education	Beds	2,735	26	0	0	72	0	21
22	24	Travel and Seminar	Beds	2,735	26	102,532	0	72	2,699	22
23	25	Other Admin. Staff Transportatio	Beds	2,735	26	0	0	72	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,735	26	297,962	0	72	7,844	24
25	TOTALS					$ 10,574,147	$ 7,569,454		$ 278,369	25

Facility Name & ID Number Heritage Health-Minonk # 0048058 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 [x] NO [ ]

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

Name of Related Organization: Heritage Operations Group
Street Address: box 3188
City / State / Zip Code: Bloomington, Il 61701
Phone Number: ( )
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	27	Other	Beds	2,735	26	$	$	72	$	1
2	30	Depreciation	Beds	2,735	26	462,659		72	12,180	2
3	31	Amortization of Pre-Op & Org	Beds	2,735	26			72		3
4	32	Interest	Beds	2,735	26	10,650		72	280	4
5	33	Real Estate Taxes	Beds	2,735	26	1,164		72	31	5
6	34	Rent-Facility & Grounds	Beds	2,735	26	173,045		72	4,555	6
7	35	Rent-Equipment & Vehicles	Beds	2,735	26	26,702		72	703	7
8	36	Other	Beds	2,735	26			72		8
9	38	Medically Nec Transportation	Beds	2,735	26			72		9
10	39	Ancillary Service Centers	Beds	2,735	26			72		10
11	40	Barber and Beauty Shops	Beds	2,735	26			72		11
12	41	Coffee and Gift Shops	Beds	2,735	26			72		12
13	42	Other	Beds	2,735	26			72		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	$		$ 17,749	25

Facility Name & ID Number Heritage Health-Minonk # 0048058 Report Period Beginning: 01/01/12 Ending: 12/31/12

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Bank of America		x	Mortgage			$	$ 782,556			$ 43,227	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							11,920	6
7												7
8												8
9	TOTAL Facility Related						$	$ 782,556			$ 59,920	9
	B. Non-Facility Related*											
10	Interest Income										(586)	10
11												11
12	Allocated Corporate										280	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (306)	14
15	TOTALS (line 9+line14)						$	$ 782,556			$ 59,614	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.)**

Facility Name & ID Number Heritage Health-Minonk # 0048058 Report Period Beginning: 01/01/12 Ending: 12/31/12

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 31,256	2
3. Under or (over) accrual (line 2 minus line 1).		$ 31,256	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.		$ 31,256	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2007		8
2008		9
2009		10
2010		11
2011	31,256	12

FOR BHF USE ONLY

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-Minonk COUNTY Woodford

FACILITY IDPH LICENSE NUMBER 0048058

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	0607407010		$ 11,987.00	$ 31,256.00
2.	0607407011		$ 19,269.00	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 31,256.00	$ 31,256.00

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.

Facility Name & ID Number Heritage Health-Minonk # 0048058 Report Period Beginning: 01/01/12 Ending: 12/31/12

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 7,560 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (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 [x] (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 [x] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$ 25,000	1
2					2
3	TOTALS			$ 25,000	3

Facility Name & ID Number Heritage Health-Minonk # 0048058 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	72				$ 1,039,908	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Smoke Detectors (45)			1998	3,267						9
10	Compressor			1998	1,047						10
11	Generator			1998	12,140						11
12	A/C Repair			1998	1,518						12
13	Plumbing Repair			1998	4,956						13
14											14
15	Water Heater			1996	2,603						15
16	Resident Room Renovating			1996	8,483						16
17	Exterior Painting & Renovation			1996	4,806						17
18	Nurse Call System			1996	3,803						18
19	Garbage Disposal			1996	867						19
20	Boiler Repair			1996	4,436						20
21	Receptionist Work Area Renovation			1996	1,260						21
22	Hot Water Heater			1996	505						22
23	Exterior Signage			1996	1,680						23
24	Interior Rehab			1996	146,288						24
25	Interior Rehab			1996	22,963						25
26	Code Alert System			1996	1,319						26
27											27
28	Interior Rehab			1997	33,578						28
29	Interior Rehab			1997	168						29
30	Building Purchase Offset			1997	(141,199)						30
31											31
32											32
33	C/O Allocation					12,180			(12,180)		33
34	Book Depreciation					119,501		119,501			34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Health-Minonk # 0048058 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	
37	Door Alarm System	1999	$ 10,116	$		$	$	$	37
38	Plumbing / Water Heater	1999	3,170						38
39	Sewage Ejector	1999	3,042						39
40									40
41	Water Heater	2000	3,293						41
42	Remove and replace patio	2000	5,890						42
43									43
44	Garbage Disposal	2001	922						44
45	Painting--Hallways/Resident rooms	2001	2,444						45
46									46
47	Water Faucet	2002	1,656						47
48	Boiler	2002	17,945						48
49	Shower Faucet	2002	2,398						49
50									50
51	Roof	2003	30,757						51
52	Faucets	2003	1,915						52
53	Compressor	2003	1,126						53
54	Disposal	2003	970						54
55									55
56	Water Heater	2004	3,889						56
57	Hot Water Storage Tank	2004	1,744						57
58	Ansul System	2004	1,455						58
59	Door Alarm System	2004	10,914						59
60	Heat Exchanger	2004	1,518						60
61									61
62	Sewage Ejector	2005	3,310						62
63	Circulator Motor	2005	892						63
64	Dry Valve	2005	2,410						64
65	Integrety Bather	2005							65
66	Exterior Doors	2005	6,106						66
67	Sprinkler Repair	2005	2,957						67
68	Glass Door	2005							68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,275,235	$ 131,681		$ 119,501	$ (12,180)	$	70

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

Facility Name & ID Number Heritage Health-Minonk # 0048058 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 12A, Carried Forward		$ 1,275,235	$ 131,681		$ 119,501	$ (12,180)	$	1
2	Climate Control	2006	1,299						2
3	Shower Faucet	2006	444						3
4	Sprinkler main line	2006	6,672						4
5	Compressor	2006	1,580						5
6	Corridor Rehab	2006	5,855						6
7	Rooftop A/C	2006	8,235						7
8	Audit ADJ 2006	2006	(1,227)						8
9	Fire Alarm	2007	39,698						9
10	Chiller	2007	11,569						10
11	Bearing Assembly	2007	1,109						11
12	Sprinkler	2007	2,180						12
13	HVAC	2007	876						13
14	Landscaping	2007	9,585						14
15	Thermostat	2007	7,722						15
16	Audit ADJ 2007	2007	(6,433)						16
17	Nurse Call System	2008	125,184						17
18	Soffit & Facia	2008	14,880						18
19	Water Heater	2008	9,193						19
20	Wonderguard	2008	8,777						20
21	Wireless phone system	2008	22,250						21
22	Cables for Nurse Call system	2008	9,897						22
23									23
24	Shower Faucet	2009	6,569						24
25	Front Doors	2009	6,370						25
26	Sprinkler System	2009	43,180						26
27	Water Heater	2009	7,017						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,617,716	$ 131,681		$ 119,501	$ (12,180)	$	34

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

Facility Name & ID Number Heritage Health-Minonk # 0048058 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		$ 1,617,716	$ 131,681		$ 119,501	$ (12,180)	$	1
2									2
3	Air Compressor	2010	2,800						3
4	Remodel: Paint resident rooms/labor & flooring	2010	50,213						4
5	Data System	2010	9,854						5
6	Garage Heater	2010	2,831						6
7									7
8	Facility Remodel: Skilled Care Wing & Therapy Dept -	2011	529,930						8
9	Flooring, Paint, lighting & labor								9
10	A/C chiller	2011	75,594						10
11	Water Heater	2011	6,875						11
12	Sprinkler Heads	2011	7,157						12
13									13
14	Facility Remodel: Shelter Care- Flooring, Paint, lighting	2012	315,942						14
15	& labor								15
16	Therapy Sewer line	2012	13,193						16
17	Lighting: upgrade throughout facility including but not	2012	4,065						17
18	limited to, resident rooms, common areas, and offices								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)		$ 2,636,170	$ 131,681		$ 119,501	$ (12,180)	$	34

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

Facility Name & ID Number Heritage Health-Minonk # 0048058 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 12C, Carried Forward		$ 2,636,170	$ 131,681		$ 119,501	$ (12,180)	$	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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,636,170	$ 131,681		$ 119,501	$ (12,180)	$	34

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

Facility Name & ID Number Heritage Health-Minonk # 0048058 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	$ 588,278	$ 59,035	$ 59,035	$		$	71
72	Current Year Purchases	26,677						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 614,955	$ 59,035	$ 59,035	$		$	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)	$ 3,276,125	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 190,716	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 178,536	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (12,180)	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.

Facility Name & ID Number Heritage Health-Minonk # 0048058 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

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: *

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	$

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: $ 10,219 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-Minonk # 0048058 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.)

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		120		120
3	Classroom Wages (a)				
4	Clinical Wages (b)		3,406		3,406
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 3,526	$	$ 3,526
10	SUM OF line 9, col. 1 and 2 (e)	$ 3,526			

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.

Facility Name & ID Number Heritage Health-Minonk # 0048058 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 121,110	$		$ 121,110	1
2	Licensed Speech and Language Development Therapist		hrs			12,211			12,211	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			132,699	1,601		134,300	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				186,818		186,818	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					20,660			20,660	13
14	TOTAL			$		$ 286,680	$ 188,419		$ 475,099	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.

STATE OF ILLINOIS

Facility Name & ID Number Heritage Health-Minonk # 0048058 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	$ 310	$	1
2	Cash-Patient Deposits	3,125		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	560,519		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,312		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(482,537)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 84,729	$	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)**	$ 84,729	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 154,142	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,125		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	129,110		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,831		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	Assessment Tax	55,863		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 346,071	$	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)**	$ 346,071	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (261,342)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 84,729	$	48

***(See instructions.)**

Facility Name & ID Number Heritage Health-Minonk # 0048058 Report Period Beginning: 01/01/12 Ending: 12/31/12

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (156,878)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (156,878)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(104,464)	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)**	$ (104,464)	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)**	$ (261,342)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Heritage Health-Minonk # 0048058 Report Period Beginning: 01/01/12 Ending: 12/31/12

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,797,842	1
2	Discounts and Allowances for all Levels	(944,853)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,852,989	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	937,129	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 937,129	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	(18)	12
13	Barber and Beauty Care	2,649	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	336,662	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	11,258	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 350,551	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	586	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 586	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)**	$ 3,141,255	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	637,909	31
32	Health Care	1,509,983	32
33	General Administration	760,328	33
	B. Capital Expense		
34	Ownership	337,499	34
	C. Ancillary Expense		
35	Special Cost Centers		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)***	$ 3,245,719	40
41	**Income before Income Taxes (line 30 minus line 40)****	(104,464)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (104,464)	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-Minonk # 0048058 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,896	2,024	$ 64,487	$ 31.86	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	6,807	7,402	189,353	25.58	3
4	Licensed Practical Nurses	3,503	3,972	85,179	21.44	4
5	CNAs & Orderlies	35,936	38,472	459,812	11.95	5
6	CNA Trainees			3,406		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,108	3,496	65,792	18.82	8
9	Activity Director					9
10	Activity Assistants	5,118	5,388	61,945	11.50	10
11	Social Service Workers	1,396	1,861	35,081	18.85	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,958	15,103	162,915	10.79	15
16	Dishwashers					16
17	Maintenance Workers	5,001	5,282	73,569	13.93	17
18	Housekeepers	5,297	5,768	54,662	9.48	18
19	Laundry	2,921	3,053	31,839	10.43	19
20	Administrator	1,950	2,080	78,162	37.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,610	6,178	107,077	17.33	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)	92,501	100,079	$ 1,473,279 *	$ 14.72	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		747		36
37	Medical Records Consultant		2,294		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,320		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		1,702		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 9,063		49

C. CONTRACT NURSES

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

Facility Name & ID Number Heritage Health-Minonk # 0048058 Report Period Beginning: 01/01/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kim Seaman			$ 78,162
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 78,162

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Operations Group	Mgt	$ 134,521
		0
		0
Legal adj to Zero		3,892
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 138,413

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 33,359
Unemployment Compensation Insurance	35,808
FICA Taxes	112,706
Employee Health Insurance	85,725
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
	0
Other Benefits	8,221
Central Office Allocation	28,776
TOTAL (agree to Schedule V, line 22, col.8)	$ 304,595

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	516
Health Care Worker Background Check	
(Indicate # of checks performed)	1,055
Patient Background Checks	
	10,260
Dues & Subscriptions	5,146
License & Fees	4,831
Central Office Allocation	5,382
Less: Public Relations Expense	(10,260)
Non-allowable advertising	(446)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,484

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	7,108
	0
Seminar Expense	1,710
	(6,819)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

**See instructions.

Facility Name & ID Number Heritage Health-Minonk # 0048058 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	Amount of Expense Amortized Per Year								
					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-Minonk # 0048058 Report Period Beginning: 01/01/12 Ending: 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. $ **26,901**
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. $ **3,094**

(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 Line #	Adjustment Amount				
1009	PETTY CASH	310						1,009	1,009	PETTY C	310
1010	CASH IN BANK							1,100	1,100	ACCTS R	560,519
1040	CASH IN BANK-PAYROLL							1,101	1,101	ALLOW. FOR UNCOLLECTIBI	
1100	ACCOUNTS RECEIVABLE	560,519						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	3,312
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	3,312						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 I	0
1475	BUILDING & IMPROVEMEN	0						1,530	1,530	RESIDEN	3,125
1490	ACCUM DEPR-BUILDING	0						1,550	1,550	LOAN FE	0
1530	RESIDENT FUNDS	3,125						1,551	1,551	LOAN FEES ADDED	
1550	LOAN FEES	0						1,850	1,850	INTERCC	(482,537)
1560	REAL ESTATE TAX ESCROW							2,010	2,010	ACCOUN	(154,142)
1575	REIMBURSABLE PURCHASES							2,100	2,095	BONUSES PAYABLE	
1850	INTRACOMPANY	-482,537						2,100	2,100	ACCRUE	(40,397)
2010	ACCOUNTS PAYABLE	-154,142						2,100	2,100	PR CLEARING-BENEFITS	
2095	BONUSES PAYABLE							2,100	2,100	PR CLEARING-LABOR	
2100	ACCRUED PAYROLL	-40,397						2,110	2,110	ACCRUE	(88,713)
2110	ACCRUED VACATION PAY	-88,713						2,120	2,120	U.C. TAXES PAYABLE	

2120	UC TAXES PAYABLE		
2125	FICA TAX PAYABLE	-3,831	-3,831
2130	FIT PAYABLE		
2140	STATE W/H PAYABLE		0
2145	EARNED INCOME CREDIT		
2150	UC FED CREDIT REDUCTION		
2230	PAYROLL SAVINGS		
2235	IRA W/HOLDINGS		
2240	UNITED WAY		
2245	GROUP INSURANCE PAYABLE		
2246	GROUP INSURANCE PAYABLE-CAFETERIA		
2260	WAGE GARNISHMENTS		
2280	MISC PAYROLL DEDUCTIONS		
2300	ACCRUED INTEREST PAYA	0	
2310	SALES TAX PAYABLE		
2320	IPA PAYMENTS PAYABLE	-55,863	
2350	REAL ESTATE TAX PAYAB	0	
2385	ACTIVITY FUND	0	
2390	SECURITY DEPOSITS	0	
2391	VOLUNTEER FUND		
2393	HEART FUND/BAZAAR		
2395	DEFERRED INC EMP & MEM		
2400	CURRENT PORTION LT DEBT		
2460	INCOME TAXES PAYABLE		
2512	DUE TO RESIDENTS	-3,125	
2600	MORTGAGE PAYABLE	0	
2650	EQUIPMENT LOAN PAYABLE		
2695	CURRENT PORTION LT DEBT		
2696	DEFERRED INCOME TAXES		
2710	COMMON STOCK		
2720	RETAINED EARNINGS	156,878	
2970	PROFIT/LOSS FOR PERIOD	104,464	
3007.1	PATIENT DAYS-PRIVATE	8,242	

2,125	2,125	FICA TA:	(3,831)
2,130	2,130	FEDERAL W/H TAX PAYABLI	
2,140	2,140	STATE W/H TAX PAYABLE	
2,152	2,152	WORKERS COMP ACCRUAL	
2,225	2,225	EMPLOYEEE INSURANCE RE:	
2,230	2,230	PAYROLL SAVINGS	
2,235	2,240	UNITED FUND	
2,240	2,246	GROUP INSURANCE - CAFETI	
2,246	2,250	401K W/H	
2,250			
2,260	2,260	WAGE GARNISHMENT	
2,300	2,300	ACCRUE	0
2,320	2,320	IPA PAYI	(55,863)
2,350	2,350	REAL ES	0
2,385			0
2,400	2,400	CURRENT PORTION OF LT DI	
2,512	2,512	DUE TO I	(3,125)
2,600	2,600	LASALLI	0
2,600			
2,625	2,625	LASALLE CONSTR. LOAN #2	
2,625			
2,695	2,695	CURRENT PORTION OF LT DI	
2,720	2,720	RETAINI	156,878
		net incom	104,464
		balance	0

3,007

3007.2		PATIENT DAYS-IPA	7,073						3,007
3007.3		PATIENT DAYS-MEDICARE	1,646						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 &	-2,745,499	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	-50,637	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	-336,662	0	0	0	0		3,101
3101	17	DRUGS-OTHER							3,110
3110	6	PT-PRIVATE	-937,129	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	944,853	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	-2,649		0	0	0	0			3,560
3560		12	ACTIVITY FUND INCOME	0		0	0	0	0			3,570
3570		12	VENDING INCOME/EXPENS	18		0	0	0	0			3,590
3580		12	MANAGEMENT FEES			0	0	0	0			3,595
3590		1	EQUIPMENT RENTAL	-1,706		0	0	0	0			3,600
3595		21	RESIDENT TRANSPORTATI	-11,258		0	0	0	0			4,110
3600		21	MISC INCOME	0		0	0	0	0			4,111
4110			GENERAL & ADMINIST WA	101,634	107,077	21	1	17	0			4,115
4111			ADMINISTRATOR WAGES	78,162	78,162	17	1	0	0			4,120
4115			VACATION & SICK - G&A	5,443		21	1	0	0			4,125
4120	4475		EMPLOYEE BENEFITS	8,221	275,819	22	3	0	0			4,130
4125			EMPLOYEE HEPETITIS VAC	0		22	3	0	0			4,135
4130			EMPLOYEE SCHOLORSHIP	0		21	1	0	0			4,250
4135			EMPLOYEE SCHOLORSHIP	0		23	3	0	0			4,255
4220			DIRECTORS FEES	0	0	18	3	0	0			4,260
4250	4255		OFFICE SUPPLIES	14,614	14,614	21	2	0	0			4,275
4260			TELEPHONE	5,168	5,168	21	3	0	0			4,276
4275			TRAINING & EMPLOYEE D	2,545	2,545	23	3	16	-546	**		4,280
4280			GENERAL TRAVEL	7,108	8,818	24	3	16	0			4,281
4281			MEAL EXPENSE FOR TRAV	0		24	3	19	0			4,285
4285			EDUCATION & SEMINAR	1,710		24	3	19	-9,518	***		4,289
4290			HELP WANTED ADVERTISI	516	59,143	20	3	0	0	-26,901		4,290
4291			PROMOTIONAL ADVERTIS	10,434		20	3	25	-10,434			4,291
4292			PUBLIC RELATIONS	10,260		20	3	25	-10,260			4,292
4300			LICENSES & FEES	31,732		20	3	17	0			4,300
4310			DUES & SUBSCRIPTIONS	5,146		20	3	17	-446			4,310
4320			CONTRIBUTIONS	0		27	3	20	0			4,320
4350			PROFESSIONAL FEES	3,892	138,413	19	3	22	-3,892			4,350
4355			MEDICAL DIRECTOR	747	747	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	2,294		10	3	0	0	4,364
4363	PHARMACIST FEES	4,320		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	1,702	1,702	12	3	0	0	4,383
4370	TV RENTAL	8,122		35	3	5	0	4,390
4380	INCOME TAXES		40,000	27	3	26	0	4,400
4383	BACKGROUND CHECKS	1,055		20	3	26	0	4,401
4400	PAYROLL TAXES	140,602		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	7,912		22	3	0	0	4,420
4410	GROUP INSURANCE	85,725		22	3	0	0	4,430
4420	LIABILITY INSURANCE	30,569	30,569	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSURA	33,359		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	134,521		19	3	34	0 **	4,460
4460	BAD DEBTS	40,000		27	3	24	-40,000	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	2,097	10,219	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	71,228	73,569	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	2,341		6	1	0	0	4,510
5130	ELECTRIC	31,628	64,169	5	3	0	0	4,600
5131	NATURAL GAS	16,463		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	16,078		5	3	0	0	5,130
5134	TRASH COLLECTION	7,616	32,238	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	22,997	57,773	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN	34,776		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC	24,622		6	3	0	0	5,140
5210	DIETARY WAGES	157,766	162,915	1	1	0	0	5,160
5220	DIETARY SICK & VAC	5,149		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	126,967	123,873	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	1,821	6,348	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	1,132		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	3,395		1	2	0	0	5,260
5295	MEAL CREDIT	-3,094		2	2	0	0	5,270
5310	LAUNDRY WAGES	30,240	31,839	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	1,599		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	4,542	8,115	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	3,573		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	52,645	54,662	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VA	2,017		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	8,530	22,408	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	13,878		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		864,623	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	179,022		10	1	0	0	6,020
6030	DON WAGES	64,487		10	1	0	0	6,030
6035	ADON	0		10	1	0	0	6,035
6040	RN SICK & VACATION	10,331		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	81,166		10	1	0	0	6,120
6120	LPN WAGES-NON MEDICA	0		10	1	0	0	6,140
6130	LPN WAGES OTHER			10	1	0	0	6,220
6140	LPN SICK & VACATION	4,013		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDIC	442,742		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	17,070		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 WA	3,406	3,406	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	120	120	13	2	0	0	6,290
6260	NURSE AIDE TRAINING RE	0		0	0	0	0	6,295
6270	REHAB WAGES	62,802		10	1	0	0	6,390
6275	REHAB SICK & VAC	2,990		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0		7,280
6290	NURSING SUPPLIES	48,436	54,987	10	2	0	0		7,281
6295	NURSING SUPPLIES	1,104		10	2	0	0		7,380
6390	REPLACEMENT-NURSING	5,447		10	2	0	0		7,391
6490	NURSING OTHER	418	7,032	10	3	0	0		7,393
7280	DRUG PURCHASES	87,562	188,419	39	2	0	0	***	7,510
7281	DRUG PURCHASES-OTHER	99,256		39	2				7,540
7380	LABORATORY SERVICES	20,660	286,680	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	58,810	61,945	11	1	0	0		7,720
7540	ACTIVITIES SICK & VAC	3,135		11	1	0	0		7,730
7590	ACTIVITIES SUPPLIES	5,241	5,241	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	132,699		39	3	0	0	***	7,890
7660	PT SUPPLIES	1,601		39	2	0	0		7,960
7710	SOCIAL SERVICE WAGES	32,239	35,081	12	1	0	0		8,120
7720	SOCIAL SERVICE SICK & V	2,842		12	1	0	0		8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0		8,130
7740	OT FEE	121,110		39	3	0	0	***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0		9,510
7770	SPEECH THERAPY FEE	12,211		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	0	0	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	315,360	315,360	34	3	0	0		

8120	INTEREST EXPENSE	11,920	11,920	32	3	14	-586	
8130	DEPRECIATION	0	0	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	60,773
9510	INTEREST INCOME	-586		32	0	10	0	
9520	MISC NON-OPERATING INC	0		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	
		3,245,133	3,245,719					
			586					
GRAND TOTALS		104,464					-75,682	
		(NET INCOME)						
		0						

FACILITY NAME:	
FACILITY ID:	0
FACILITY UNITS:	89
BALANCE SHEET TOTAL	0

	G/L	RECAP CENSUS
PP	8,242	8,242
IPA	7,073	7,073
medicare	1,646	1,646
		16,961

IPA BEDHOLDS	0
PP BEDHOLDS	0
PP CONVERS	0

LES

E

FUND

ERIA

EBT

EBT

3,007 PATIENT 8,242

3,007	PATIENT	7,073
3,007	PATIENT	1,646
		0
3,010	BASIC CI	(2,745,499)
3,020	BASIC CI	0
3,030	BASIC CI	0
		0
		0
		0
		0
3,080	NURSINC	(50,637)
3,081	NURSINC	0
3,082	NURSINC	0
3,083	NURSINC	0
3,100	DRUGS-N	(336,662)
		0
3,110	PHYSICA	(937,129)
		0
3,112	PHYSICA	0
3,113	PHYSICA	0
3,140	LABORATORY INCOME	
		0
3,152	ST/OT TH	0
3,153	ST/OT TH	0
3,185	REHAB/ISOLATION/OTHER CHG	
3,410	IPA/OTH	0
3,411	MEDICA	0
3,420	MEDICA	933,156

3,520	RENT IN(	0
3,530	BEAUTY	(2,649)
		0
3,570	VENDIN(	18
3,590	EQUIPMI	(1,706)
3,595	RESIDEN	(11,258)
3,600	MISC IN(	0
4,110	G&A WA	101,634
4,111	ADMINIS	78,162
4,115	G&A PT(	5,443
4,120	EMPLOY	9,145
		0
4,130	EMPLOY	0
4,135	EMPLOY	0
4,250	OFFICE S	4,647
4,255	POSTAG	1,634
4,260	TELEPH(	5,168
4,275	TRAININ	2,545
		0
4,280	GENERA	7,108
4,281	MEAL E)	0
4,285	EDUCAT	1,710
4,289	MEETIN(	0
4,290	HELP W/	516
4,291	PROMOT	10,434
4,292	PUBLIC I	10,260
4,300	LICENSE	31,732
4,310	DUES & S	5,146
4,320	CONTRI	0
4,350	PROFESS	3,892
4,355	MEDICA	747
		2,294
		4,320

4,364	SOCIAL S	1,702
4,370	TV RENT	8,122
4,383	BACKGR	1,055
4,390	OTHER T	0
4,400	PAYROL	140,602
4,401	PAYROL	7,912
4,410	GROUP I	85,725
4,420	LIABILIT	30,569
4,430	WORKM.	31,673
4,435	W/C-FIRS	892
4,436	DRUG TE	794
4,450	MANAGI	134,521
4,460	BAD DEI	40,000
4,461	BAD DEI	11,697
4,470	LOST ITI	0
4,475	UNIFORM	(924)
4,486	SERVICE	13,167
4,490	MISC EX	5
4,496	MISC. M.	8,333
4,510	REAL ES	0
4,600	LEASED	2,097
5,110	MAINTEI	71,228
5,120	MAINTEI	2,341
5,130	ELECTRI	31,628
5,131	NATURA	16,463
5,133	WATER &	16,078
5,134	TRASH C	7,616
5,140	PROP/PL.	22,997
5,160	GENERA	34,776
5,165	MAINTEI	11,455
5,210	DIETARY	157,766
5,220	DIETARY	5,149
5,248	FOOD PU	126,962

5,250	SUPPLIE	1,821
5,260	REPLACI	1,132
5,270	KITCHEN	3,395
5,295	MEAL IN	(3,094)
5,310	LAUNDR	30,240
5,340	LAUNDR	1,599
5,370	REPLACI	4,542
		0
5,390	SUPPLIE	3,573
5,410	HOUSEK	52,645
5,440	HOUSEK	2,017
5,480	SUPPLIE	8,530
5,490	SUPPLIE	13,878
6,020	RN WAG	179,022
6,030	DON WA	64,487
6,035	ADON W	0
6,040	RN PTO &	10,331
6,120	LPN WAG	81,166
6,140	LPN PTO	4,013
6,220	AIDES W	442,742
6,240	AIDES PT	17,070
		0
		3,406
		120
		0
6,270	REHAB V	62,802
6,275	REHAB P	2,990
6,290	NURSING	48,436
6,295	NURSING	1,104
6,390	REPLACI	5,447
6,490	OTHER	418

7,280	DRUG PU	87,562
7,281	DRUG PU	99,256
7,380	LABORA	5,318
7,390	X-RAY S	637
		14,705
7,510	ACTIVIT	58,810
7,540	ACTIVIT	3,135
7,590	ACTIVIT	5,241
7,620	PHYSICA	132,699
7,660	P.T. SUPI	1,601
7,710	SOCIAL S	32,239
7,720	SOCIAL S	2,842
7,730	SOCIAL S	0
7,740	OCCUPA	121,110
		0
7,770	SPEECH	12,211
7,820	BEAUTIC	0
		0
		0
8,120	INTERES	0
		11,920
8,130	DEPRECI	0
		0
9,510	INTERES	(586)
9,520	MISC NO	0
4,220		0
8,100		315,360
9,702		0
5,230		0
		104,464

Expenses Fixed Assets

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