



Facility Name & ID Number Heritage Health-Elgin

# 0048132 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	94	Skilled (SNF)	94	34,404	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	94	TOTALS	94	34,404	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	23,093	3,043	3,506	29,642	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,093	3,043	3,506	29,642	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.16%

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 07/2007

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 3,506

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.

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
	<b>A. General Services</b>										
1	Dietary	253,538	6,834		260,372		260,372	5,826	266,198		1
2	Food Purchase		216,706		216,706		216,706	43	216,749		2
3	Housekeeping	100,990	43,034		144,024		144,024		144,024		3
4	Laundry	55,093	16,090		71,183		71,183		71,183		4
5	Heat and Other Utilities			103,144	103,144		103,144	1,389	104,533		5
6	Maintenance	81,766	50,543	50,098	182,407		182,407	14,343	196,750		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	491,387	333,207	153,242	977,836		977,836	21,601	999,437		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000	2,440	14,440		9
10	Nursing and Medical Records	1,875,077	95,152	36,446	2,006,675		2,006,675	1	2,006,676		10
10a	Therapy		335,684	621,229	956,913	(337,665)	619,248	80,834	700,082		10a
11	Activities	71,073	7,076		78,149		78,149		78,149		11
12	Social Services	38,855		3,614	42,469		42,469		42,469		12
13	CNA Training							972	972		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,985,005	437,912	673,289	3,096,206	(337,665)	2,758,541	84,247	2,842,788		16
	<b>C. General Administration</b>										
17	Administrative	101,880			101,880		101,880		101,880		17
18	Directors Fees										18
19	Professional Services			276,482	276,482		276,482	(261,052)	15,430		19
20	Dues, Fees, Subscriptions & Promotions			105,255	105,255	(51,606)	53,649	(34,962)	18,687		20
21	Clerical & General Office Expenses	234,124	31,332	18,595	284,051		284,051	264,622	548,673		21
22	Employee Benefits & Payroll Taxes			558,969	558,969		558,969	37,569	596,538		22
23	Inservice Training & Education			4,646	4,646		4,646	(2,647)	1,999		23
24	Travel and Seminar			7,070	7,070		7,070	(5,071)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			66,735	66,735		66,735	10,241	76,976		26
27	Other (specify):*			99,980	99,980		99,980	(99,980)			27
28	<b>TOTAL General Administration</b>	336,004	31,332	1,137,732	1,505,068	(51,606)	1,453,462	(91,280)	1,362,182		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,812,396	802,451	1,964,263	5,579,110	(389,271)	5,189,839	14,568	5,204,407		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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
	<b>D. Ownership</b>										
30	Depreciation						127,715	127,715			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			22,818	22,818	22,818	34,468	57,286			32
33	Real Estate Taxes						45,733	45,733			33
34	Rent-Facility & Grounds			411,720	411,720	411,720	(405,773)	5,947			34
35	Rent-Equipment & Vehicles			21,627	21,627	21,627	918	22,545			35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			456,165	456,165	456,165	(196,939)	259,226			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers					337,665	337,665	337,665			39
40	Barber and Beauty Shops		108		108		108	108			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee					51,606	51,606	51,606			42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>		108		108	389,271	389,379	389,379			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,812,396	802,559	2,420,428	6,035,383		6,035,383	(182,371)	5,853,012		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-Elgin

# 0048132

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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer-</b>	<b>BHF USE</b>	
			<b>ence</b>	<b>ONLY</b>	
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	(2,196)			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)	(2,647)			16
17	Non-Care Related Fees	(1,121)			17
18	Fines and Penalties				18
19	Entertainment	(8,595)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(13,809)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(99,980)			24
25	Fund Raising, Advertising and Promotional	(40,867)			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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (169,215)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	(13,156)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (13,156)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (182,371)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>					
48		49		50	51
					52

Heritage Health-Elgin

ID# 0048132

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		(1,121)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(13,809)	19	22
23				23
24		(99,980)	27	24
25		(40,867)	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	<b>Total</b>		(155,777)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health-Elgin# 0048132

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	5,826	0	0	0	0	0	0	0	0	5,826	1
2	Food Purchase	0	0	43	0	0	0	0	0	0	0	0	43	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	1,389	0	0	0	0	0	0	0	0	1,389	5
6	Maintenance	0	0	14,343	0	0	0	0	0	0	0	0	14,343	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>21,601</b>	<b>0</b>	<b>21,601</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	2,440	0	0	0	0	0	0	0	0	2,440	9
10	Nursing and Medical Records	0	0	1	0	0	0	0	0	0	0	0	1	10
10a	Therapy	0	80,834	0	0	0	0	0	0	0	0	0	80,834	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	972	0	0	0	0	0	0	0	0	972	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>80,834</b>	<b>3,413</b>	<b>0</b>	<b>84,247</b>	<b>16</b>							
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(13,809)	(262,673)	15,430	0	0	0	0	0	0	0	0	(261,052)	19
20	Fees, Subscriptions & Promotions	(41,988)	0	7,026	0	0	0	0	0	0	0	0	(34,962)	20
21	Clerical & General Office Expenses	0	0	264,622	0	0	0	0	0	0	0	0	264,622	21
22	Employee Benefits & Payroll Taxes	0	0	37,569	0	0	0	0	0	0	0	0	37,569	22
23	Inservice Training & Education	(2,647)	0	0	0	0	0	0	0	0	0	0	(2,647)	23
24	Travel and Seminar	(8,595)	0	3,524	0	0	0	0	0	0	0	0	(5,071)	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	10,241	0	0	0	0	0	0	0	0	10,241	26
27	Other (specify):*	(99,980)	0	0	0	0	0	0	0	0	0	0	(99,980)	27
28	<b>TOTAL General Administration</b>	<b>(167,019)</b>	<b>(262,673)</b>	<b>338,412</b>	<b>0</b>	<b>(91,280)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(167,019)</b>	<b>(181,839)</b>	<b>363,426</b>	<b>0</b>	<b>14,568</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health-Elgin

# 0048132

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)	
	<b>D. Ownership</b>													
30	Depreciation	0	111,814	0	15,901	0	0	0	0	0	0	0	127,715	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,196)	36,298	0	366	0	0	0	0	0	0	0	34,468	32
33	Real Estate Taxes	0	45,693	0	40	0	0	0	0	0	0	0	45,733	33
34	Rent-Facility & Grounds	0	(411,720)	0	5,947	0	0	0	0	0	0	0	(405,773)	34
35	Rent-Equipment & Vehicles	0	0	0	918	0	0	0	0	0	0	0	918	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(2,196)</b>	<b>(217,915)</b>	<b>0</b>	<b>23,172</b>	<b>0</b>	<b>(196,939)</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(169,215)</b>	<b>(399,754)</b>	<b>363,426</b>	<b>23,172</b>	<b>0</b>	<b>(182,371)</b>	<b>45</b>						

**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>80,834</u>	<u>80,834</u>	2
3	V							3
4	V	<u>19 Adjustment for Related Organization</u>	<u>262,673</u>	<u>Heritage Operations Group, LLC</u>	<u>0.00%</u>		<u>(262,673)</u>	4
5	V							5
6	V	<u>34 Adjustment for Related Organization</u>	<u>411,720</u>	<u>Heritage Manor Real Estate, LLC</u>	<u>0.00%</u>		<u>(411,720)</u>	6
7	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>45,693</u>	<u>45,693</u>	7
8	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>31,525</u>	<u>31,525</u>	8
9	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>111,814</u>	<u>111,814</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	<b>Total</b>		<b>\$ 674,393</b>			<b>\$ 274,639</b>	<b>\$ * (399,754)</b>	14

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

Facility Name &amp; ID Number

Heritage Health-Elgin

# 0048132

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	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.		\$	\$ 5,826	15
16	V	2 Food Purchase					43	16
17	V	3 Housekeeping					0	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					1,389	19
20	V	6 Maintenance					14,343	20
21	V	7 Other					0	21
22	V	9 Medical Director					2,440	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					972	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					15,430	31
32	V	20 Fees, Subscription, Promotions					7,026	32
33	V	21 Clerical & General Office Expenses					264,622	33
34	V	22 Employee Benefits & Payroll Taxes					37,569	34
35	V	23 Inservice Training & Education					0	35
36	V	24 Travel and Seminar					3,524	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					10,241	38
39	Total		\$			\$	0	\$ * 363,426 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						15,901	16	
17	V	31 Amortization of Pre-Op & Org						0	17	
18	V	32 Interest						366	18	
19	V	33 Real Estate Taxes						40	19	
20	V	34 Rent-Facility & Grounds						5,947	20	
21	V	35 Rent-Equipment & Vehicles						918	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	\$ *	23,172	39

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

Facility Name & ID Number

Heritage Health-Elgin

# 0048132

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-Elgin # 0048132 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Heritage Enterprises Inc.	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-Elgin

# 0048132

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	94	\$ 5,826	1
2	2	Food Purchase	Beds	2,735	26	1,241	0	94	43	2
3	3	Housekeeping	Beds	2,735	26	0	0	94	0	3
4	4	Laundry	Beds	2,735	26	0	0	94	0	4
5	5	Heat & Other Utilities	Beds	2,735	26	40,426	0	94	1,389	5
6	6	Maintenance	Beds	2,735	26	417,328	78,403	94	14,343	6
7	7	Other	Beds	2,735	26	0	0	94	0	7
8	9	Medical Director	Beds	2,735	26	71,007	0	94	2,440	8
9	10	Nursing & Medical Records	Beds	2,735	26	33	70,119	94	1	9
10	11	Activities	Beds	2,735	26	0	0	94	0	10
11	12	Social Service	Beds	2,735	26	0	0	94	0	11
12	13	Nurse Aide Training	Beds	2,735	26	28,290	22,496	94	972	12
13	14	Program Transportation	Beds	2,735	26	0	0	94	0	13
14	15	Other	Beds	2,735	26	0	0	94	0	14
15	17	Administrative	Beds	2,735	26	0	0	94	0	15
16	18	Directors Fees	Beds	2,735	26	0	0	94	0	16
17	19	Professional Services	Beds	2,735	26	448,954	0	94	15,430	17
18	20	Fees, Subscription, Promotions	Beds	2,735	26	204,427	0	94	7,026	18
19	21	Clerical & General Office Expens	Beds	2,735	26	7,699,360	7,229,609	94	264,622	19
20	22	Employee Benefits & Payroll Tax	Beds	2,735	26	1,093,087	0	94	37,569	20
21	23	Inservice Training & Education	Beds	2,735	26	0	0	94	0	21
22	24	Travel and Seminar	Beds	2,735	26	102,532	0	94	3,524	22
23	25	Other Admin. Staff Transportatio	Beds	2,735	26	0	0	94	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,735	26	297,962	0	94	10,241	24
25	TOTALS					\$ 10,574,147	\$ 7,569,454		\$ 363,426	25

Facility Name & ID Number Heritage Health-Elgin

# 0048132

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	\$	94	\$	1
2	30	Depreciation	Beds	2,735	26	462,659	94	15,901	2
3	31	Amortization of Pre-Op & Org	Beds	2,735	26		94		3
4	32	Interest	Beds	2,735	26	10,650	94	366	4
5	33	Real Estate Taxes	Beds	2,735	26	1,164	94	40	5
6	34	Rent-Facility & Grounds	Beds	2,735	26	173,045	94	5,947	6
7	35	Rent-Equipment & Vehicles	Beds	2,735	26	26,702	94	918	7
8	36	Other	Beds	2,735	26		94		8
9	38	Medically Nec Transportation	Beds	2,735	26		94		9
10	39	Ancillary Service Centers	Beds	2,735	26		94		10
11	40	Barber and Beauty Shops	Beds	2,735	26		94		11
12	41	Coffee and Gift Shops	Beds	2,735	26		94		12
13	42	Other	Beds	2,735	26		94		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	\$		\$ 23,172	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**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
<b>A. Directly Facility Related</b>																
<b>Long-Term</b>																
1	Bank of America		x	Mortgage			\$	\$ 579,808			\$ 31,525	1				
2	Bank of America		x	Loan Fee Amort							4,773	2				
3												3				
4												4				
5												5				
<b>Working Capital</b>																
6	Bank of America		xx	Working Capital							22,818	6				
7												7				
8												8				
9	<b>TOTAL Facility Related</b>						\$	\$ 579,808			\$ 59,116	9				
<b>B. Non-Facility Related*</b>																
10	Interest Income										(2,196)	10				
11												11				
12	Allocated Corporate										366	12				
13												13				
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (1,830)	14				
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 579,808			\$ 57,286	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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
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.)		\$	45,693		2	
3. Under or (over) accrual (line 2 minus line 1).		\$	45,693		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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	45,693		7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2007	_____	8	<b>FOR BHF USE ONLY</b>		
	2008	_____	9			
	2009	_____	10			
	2010	_____	11			
	2011	45,693	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-Elgin COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0048132

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>0624201004</u>	_____	\$ 1,092.00	\$ 45,693.00
2. <u>0624201003</u>	_____	\$ 43,161.00	\$ _____
3. <u>0624201002</u>	_____	\$ 1,440.00	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>45,693.00</u>	\$ <u>45,693.00</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.**

Facility Name & ID Number Heritage Health-Elgin

# 0048132 Report Period Beginning:

01/01/12 Ending:

12/31/12

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 20,804 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				\$ <u>80,000</u>	1
2					2
3	TOTALS			\$ <u>80,000</u>	3

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	94			\$ 720,000	\$		\$	\$	4
5									5
6									6
7									7
8									8
<b>Improvement Type**</b>									
9	1989 Improvements	1989		180,739					9
10	1990 Improvements	1990		658,346					10
11	1990 Improvements	1990		4,320					11
12	1991 Improvements	1991		52,989					12
13	1992 Improvements	1992		6,777					13
14	1993 Improvements	1993		54,564					14
15	1994 Improvements	1994		81,347					15
16	1995 Improvements	1995		146,394					16
17	Remodel Resident Day Room/Nurses Station	1996		23,749					17
18	Interior Rehab	1997		751					18
19	Electric Water Heater	1997		3,965					19
20	Booster Heater	1997		1,622					20
21	Water Heater and Storage Tank	1998		6,485					21
22									22
23	Water Heater	1999		4,750					23
24	Code Alert System	1999		1,570					24
25	Resident Room Remodel--Material and Labor	1999		2,571					25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33	C/O Allocation				15,901			(15,901)	33
34	Book Depreciation				85,991		85,991		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 &amp; ID Number Heritage Health-Elgin

# 0048132

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	South Wing Remodel -- Labor / Materials	2000	\$ 14,334	\$		\$	\$	\$	37
38	Door	2000	1,535						38
39	Dry Chemical Extinguisher	2000	1,746						39
40									40
41	Water Heater	2001	4,935						41
42	Valve thermometer	2001	4,520						42
43	A/C Unit	2001	3,319						43
44	Hallway Carpet and Tile Material and Labor	2001	28,843						44
45	Wallpaper	2001	2,390						45
46	Nurse Call System	2001	21,612						46
47									47
48	Hallway and Room Carpet and Tile Material	2002	74,533						48
49	Labor	2002	68,734						49
50	Professional Fees	2002	16,497						50
51	Kitchen Pipe	2002	1,830						51
52	Shower Repairs	2002	5,063						52
53	A/C Unit	2002	5,864						53
54	Bathroom Rehab	2002	750						54
55	Condensor	2002	1,600						55
56	Hallway and Room Carpet and Tile Material --South wing	2002	5,777						56
57									57
58	Hallway and Room Carpet and Tile Material --South wing	2003	92,993						58
59	Exterior Door	2003	320						59
60	Parking Lot Sealer	2003	4,469						60
61	Door Security	2003	2,160						61
62	Ductwork	2003	6,628						62
63	compressor	2003	1,195						63
64	Blower Unit	2003	1,784						64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 2,324,370	\$ 101,892		\$ 85,991	\$ (15,901)	\$	70

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

Facility Name &amp; ID Number Heritage Health-Elgin

# 0048132

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		\$ 2,324,370	\$ 101,892		\$ 85,991	\$ (15,901)	\$	1
2									2
3	Exhaust fan	2005	1,950						3
4	Exterior Doors	2005	2,218						4
5	Compressor	2005	1,608						5
6									6
7	Fire Alarm	2006	1,714						7
8	Parking Lot	2006	2,344						8
9	Remodel Corridor --paint	2006	4,028						9
10	Water Main	2006	3,250						10
11									11
12	Roof	2007	94,451						12
13	Central Corridor paint, tile	2007	49,685						13
14	Plumbing fixtures	2007	2,400						14
15	Rooftop heat/cool unit	2007	5,565						15
16									16
17	A/C Units	2008	19,600						17
18	4 Ton A/C Unit	2008	2,600						18
19	HVAC Rooftop Unit	2008	11,000						19
20									20
21	Patio	2009	11,693						21
22	Front Entry Doors	2009	13,529						22
23	Front Office Carpet and Window Treatments	2009	3,864						23
24									24
25	Cat5 cable/wire facility	2010	6,607						25
26									26
27	Electric water heater	2011	11,750						27
28	Sign	2011	2,500						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,576,726	\$ 101,892		\$ 85,991	\$ (15,901)	\$	34

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

Facility Name & ID Number Heritage Health-Elgin

# 0048132

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		\$ 2,576,726	\$ 101,892		\$ 85,991	\$ (15,901)		1
2									2
3	Smoke Detector	2012	6,090						3
4	Aiphone	2012	7,030						4
5	Walk in Freezer	2012	5,210						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)		\$ 2,595,056	\$ 101,892		\$ 85,991	\$ (15,901)		34

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

Facility Name & ID Number Heritage Health-Elgin

# 0048132

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		\$ 2,595,056	\$ 101,892		\$ 85,991	\$ (15,901)	\$
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	TOTAL (lines 1 thru 33)	\$ 2,595,056	\$ 101,892		\$ 85,991	\$ (15,901)	\$

\*\*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	\$ 768,932	\$ 25,823	\$ 25,823	\$		\$	71
72	Current Year Purchases	17,469						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 786,401	\$ 25,823	\$ 25,823	\$		\$	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)	\$ 3,461,457	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 127,715	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 111,814	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (15,901)	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: \$ 21,627 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-Elgin # 0048132 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
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**

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

- (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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$			\$ 273,628	\$		\$ 273,628	1
2	Licensed Speech and Language Development Therapist		hrs				60,032			60,032	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs				280,817	4,771		285,588	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					330,913		330,913	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):						6,752			6,752	13
14	<b>TOTAL</b>			\$			\$ 621,229	\$ 335,684		\$ 956,913	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-Elgin# 0048132Report 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	2	
		Operating	After	
			Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 800	\$	1
2	Cash-Patient Deposits	62,074		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,671,051		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,441		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(734,074)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,024,292	\$	10
<b>B. Long-Term Assets</b>				
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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,024,292	\$	25

		1	2	
		Operating	After	
			Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 248,686	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	62,074		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	306,952		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,100		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
<b>Other Current Liabilities(specify):</b>				
36	<u>Assessment Tax</u>	120,107		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 739,919	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 739,919	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 284,373	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,024,292	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>150,815</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>150,815</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	133,558	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>133,558</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>284,373</b>	<b>24</b> *

\* 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,510,084	1
2	Discounts and Allowances for all Levels	(1,885,385)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 3,624,699</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,943,332	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,943,332</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	(118)	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	598,832	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 598,714</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,196	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 2,196</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 6,168,941</b>	<b>30</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	977,836	31
32	Health Care	3,096,206	32
33	General Administration	1,505,068	33
<b>B. Capital Expense</b>			
34	Ownership	456,165	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	108	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 6,035,383</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>133,558</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 133,558</b>	<b>43</b>

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	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$</b>	<b>49</b>

\* 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-Elgin

# 0048132

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	\$ 81,043	\$ 39.88	1
2	Assistant Director of Nursing	1,960	2,064	74,721	36.20	2
3	Registered Nurses	15,071	16,159	520,121	32.19	3
4	Licensed Practical Nurses	7,147	7,947	210,678	26.51	4
5	CNAs & Orderlies	53,180	57,579	873,284	15.17	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,235	4,656	115,230	24.75	8
9	Activity Director					9
10	Activity Assistants	5,859	6,333	71,073	11.22	10
11	Social Service Workers	2,184	2,390	38,855	16.26	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,693	21,217	253,538	11.95	15
16	Dishwashers					16
17	Maintenance Workers	3,701	3,991	81,766	20.49	17
18	Housekeepers	9,517	9,902	100,990	10.20	18
19	Laundry	4,733	5,161	55,093	10.67	19
20	Administrator	1,950	2,080	101,880	48.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,169	10,289	234,124	22.75	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)	140,303	151,800	\$ 2,812,396 *	\$ 18.53	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	12,000		36
37	Medical Records Consultant	2,426		37
38	Nurse Consultant			38
39	Pharmacist Consultant	5,640		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	3,614		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 23,680		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	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



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	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Heritage Health-Elgin# 0048132

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. \$ 51,606  
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. \$ 0
- (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	800				1,009	1,009 PETTY CASH 800
1010	CASH IN BANK					1,100	1,100 ACCTS RECEIV 1,671,051
1040	CASH IN BANK-PAYROLL					1,101	1,101 ALLOW. FOR UNCOLLECTI
1100	ACCOUNTS RECEIVABLE	1,671,051				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 RECEIPT
1135	ACCOUNTS RECEIVABLE-IC					1,145	1,145 A/R SUSPENSE-REFUNDS
1140	UNAPPLIED CASH RECEIPTS					1,200	1,200 PREPAID INSUF 24,441
1145	A/R SUSPENSE-REFUNDS					1,220	1,220 OTHER PREPAID EXPENSE
1190	ACCRUED INTEREST REC					1,300	1,300 DIETARY INVENTORY
1200	PREPAID INSURANCE	24,441				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 FURNITURE & I 0
1409	LAND	0				1,460	1,460 0
1450	FURNITURE & EQUIPMENT	0				1,475	1,475 CODE ALERT M 0
1460	ACCUM DEPR-FURN & EQU	0				1,490	1,490 ACCUM DEPR-I 0
1475	BUILDING & IMPROVEMEN	0				1,530	1,530 RESIDENT FUN 62,074
1490	ACCUM DEPR-BUILDING	0				1,550	1,550 LOAN FEES 0
1530	RESIDENT FUNDS	62,074				1,551	1,551 LOAN FEES ADDED
1550	LOAN FEES	0				1,850	1,850 INTERCOMPAN (734,074)
1560	REAL ESTATE TAX ESCROW					2,010	2,010 ACCOUNTS PA (248,686)
1575	REIMBURSABLE PURCHASES					2,100	2,095 BONUSES PAYABLE
1850	INTRACOMPANY	-734,074				2,100	2,100 ACCRUED PAY (125,629)
2010	ACCOUNTS PAYABLE	-248,686				2,100	2,100 PR CLEARING-BENEFITS
2095	BONUSES PAYABLE					2,100	2,100 PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-125,629				2,110	2,110 ACCRUED PTO (181,323)
2110	ACCRUED VACATION PAY	-181,323				2,120	2,120 U.C. TAXES PAYABLE

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAXES PA	(2,100)
2125	FICA TAX PAYABLE	-2,100	-2,100	2,130	2,130 FEDERAL W/H TAX PAYAE	
2130	FIT PAYABLE			2,140	2,140 STATE W/H TAX PAYABLE	
2140	STATE W/H PAYABLE		0	2,152	2,152 WORKERS COMP ACCRUA	
2145	EARNED INCOME CREDIT			2,225	2,225 EMPLOYEEE INSURANCE I	
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 - CAFI	
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 ACCRUED INTE	0
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYMENTS	(120,107)
2300	ACCRUED INTEREST PAYA	0		2,350	2,350 REAL ESTATE T	0
2310	SALES TAX PAYABLE			2,385		0
2320	IPA PAYMENTS PAYABLE	-120,107		2,400	2,400 CURRENT PORTION OF LT	
2350	REAL ESTATE TAX PAYAB	0		2,512	2,512 DUE TO RESIDE	(62,074)
2385	ACTIVITY FUND	0		2,600	2,600 LASALLE BANK	0
2390	SECURITY DEPOSITS	0		2,600		
2391	VOLUNTEER FUND			2,625	2,625 LASALLE CONSTR. LOAN #	
2393	HEART FUND/BAZAAR			2,625		
2395	DEFERRED INC EMP & MEM			2,695	2,695 CURRENT PORTION OF LT	
2400	CURRENT PORTION LT DEBT			2,720	2,720 RETAINED EAR	(150,815)
2460	INCOME TAXES PAYABLE				net income	(133,558)
2512	DUE TO RESIDENTS	-62,074				
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	-150,815				
2970	PROFIT/LOSS FOR PERIOD	-133,558				
3007.1	PATIENT DAYS-PRIVATE	3,043				

3007.2	PATIENT DAYS-IPA	23,093				
3007.3	PATIENT DAYS-MEDICARE	3,506				
3007.4	PATIENT DAYS-CONVERSION					
3007.5	PATIENT DAYS-LICENSED					
3007.6	PATIENT DAYS-TOTAL					
3010	1 BASIC CHARGE-PRIVATE &	-5,489,568	0	0	0	0
3015	1 PRIVATE ASSESSMENT TAX INCOME		0	0	0	0
3020	1 BASIC CHARGE-IPA	0	0	0	0	0
3030	1 BASIC CHARGE-MEDICARI	0	0	0	0	0
3035	4 DAY CARE/HOME CARE		0	0	0	0
3040	1 LIGHT NURSING CARE	0	0	0	0	0
3050	1 MEDIUM NURSING CARE		0	0	0	0
3060	1 HEAVY NURSING CARE		0	0	0	0
3061	1 SKILLED NURSING CARE					
3080	1 NURSING SUPPLIES-PRIVA	-19,082	0	0	0	0
3081	1 NURSING SUPPLIES-IPA		0	0	0	0
3082	1 NURSING SUPPLIES MED PT A		0	0	0	0
3083	1 NURSING SUPPLIES MED PT B					
3100	17 DRUGS	-598,832	0	0	0	0
3101	17 DRUGS-OTHER					
3110	6 PT-PRIVATE	-1,943,332	0	0	0	0
3111	6 PT-IPA		0	0	0	0
3112	6 PT-MEDICARE PART A		0	0	0	0
3113	6 PT-MEDICARE PART B		0	0	0	0
3130	1 PUBLIC AID ASSESSMENT INC					
3140	19 LABORATORY INCOME		0	0	0	0
3150	6 SPEECH/OT-PRIVATE		0	0	0	0
3151	6 SPEECH/OT-IPA		0	0	0	0
3152	6 SPEECH/OT-MED PART A		0	0	0	0
3153	6 SPEECH/OT MED PART B					
3410	2 IPA DISCOUNTS	1,885,385	0	0	0	0
3411	2 MEDICAID PART B DISCOUNT		0	0	0	0
3420	2 MEDICARE DISCOUNTS		0	0	0	0

3440	36 ASSESSMENT TAX EXPENSE			42	3	0	0
3520	16 RENT INCOME	0		6	0	6	0
3530	13 BEAUTY SHOP	0		0	0	0	0
3560	12 ACTIVITY FUND INCOME	0		0	0	0	0
3570	12 VENDING INCOME/EXPENSE	118		0	0	0	0
3580	12 MANAGEMENT FEES			0	0	0	0
3590	1 EQUIPMENT RENTAL	-1,434		0	0	0	0
3595	21 RESIDENT TRANSPORTATION	0		0	0	0	0
3600	21 MISC INCOME	0		0	0	0	0
4110	GENERAL & ADMINISTRATIVE WAGES	222,148	234,124	21	1	17	0
4111	ADMINISTRATOR WAGES	101,880	101,880	17	1	0	0
4115	VACATION & SICK - G&A	11,976		21	1	0	0
4120 4475	EMPLOYEE BENEFITS	10,393	558,969	22	3	0	0
4125	EMPLOYEE HEPETITIS VACATION	0		22	3	0	0
4130	EMPLOYEE SCHOLORSHIP	0		21	1	0	0
4135	EMPLOYEE SCHOLORSHIP	0		23	3	0	0
4220	DIRECTORS FEES	0	0	18	3	0	0
4250 4255	OFFICE SUPPLIES	31,332	31,332	21	2	0	0
4260	TELEPHONE	18,595	18,595	21	3	0	0
4275	TRAINING & EMPLOYEE DEVELOPMENT	4,646	4,646	23	3	16	-2,647 **
4280	GENERAL TRAVEL	3,989	7,070	24	3	16	0
4281	MEAL EXPENSE FOR TRAVEL	66		24	3	19	0
4285	EDUCATION & SEMINAR	3,015		24	3	19	-8,595 ***
4290	HELP WANTED ADVERTISING	0	105,255	20	3	0	0 -51,606
4291	PROMOTIONAL ADVERTISING	19,785		20	3	25	-19,785
4292	PUBLIC RELATIONS	21,082		20	3	25	-21,082
4300	LICENSES & FEES	55,598		20	3	17	0
4310	DUES & SUBSCRIPTIONS	7,450		20	3	17	-1,121
4320	CONTRIBUTIONS	0		27	3	20	0
4350	PROFESSIONAL FEES	13,809	276,482	19	3	22	-13,809
4355	MEDICAL DIRECTOR	12,000	12,000	9	3	0	0
4360	UTILIZATION REVIEW	0		10	3	0	0
4361	OTHER PHYSICIAN FEES			39	3	0	0

4362	MEDICAL RECORDS CONSI	2,426		10	3	0	0
4363	PHARMACIST FEES	5,640		10	3	0	0
4364	SOC SERV/ACT CONSULT	3,614	3,614	12	3	0	0
4370	TV RENTAL	21,063		35	3	5	0
4380	INCOME TAXES		99,980	27	3	26	0
4383	BACKGROUND CHECKS	1,340		20	3	26	0
4400	PAYROLL TAXES	247,068		22	3	0	0
4401	PAYROLL TAXES ADMINIS	10,100		22	3	0	0
4410	GROUP INSURANCE	241,224		22	3	0	0
4420	LIABILITY INSURANCE	66,735	66,735	26	3	0	0
4425	INSURANCE-OWNERS			22	3	21	0
4430	WORKMENS COMP INSUR/	50,184		22	3	0	0
4450	CENTRAL OFFICE FEES	262,673		19	3	34	0 **
4460	BAD DEBTS	99,980		27	3	24	-99,980
4470	LOST ITEMS-RESIDENTS	0		27	3	0	
4490	MISCELLANEOUS	0		27	3	0	0
4510	REAL ESTATE TAXES	0	0	33	3	0	0
4600	LEASED EQUIPMENT	564	21,627	35	3	16	0
5110	MAINTENANCE SALARIES	76,248	81,766	6	1	0	0
5120	MAINTENANCE SICK & VA	5,518		6	1	0	0
5130	ELECTRIC	64,904	103,144	5	3	0	0
5131	NATURAL GAS	3,727		5	3	0	0
5132	HEATING & DEISEL OIL			5	3	0	0
5133	WATER & SEWER	34,513		5	3	0	0
5134	TRASH COLLECTION	10,204	50,098	6	3	0	0
5140	PROPERTY PLANT REPLAC	11,698	50,543	6	2	0	0
5160	GENERAL REPAIR & MAIN'	38,845		6	2	0	0
5165	MAINTENANCE CONTRAC'	39,894		6	3	0	0
5210	DIETARY WAGES	243,135	253,538	1	1	0	0
5220	DIETARY SICK & VAC	10,403		1	1	0	0
5240	SALES TAX			2	3	13	0
5248	FOOD PURCHASES	216,706	216,706	2	2	0	0
5250	SUPPLIES-DISHWASHING	2,534	6,834	1	2	0	0

5260	DIETARY REPLACEMENT	516		1	2	0	0
5270	KITCHEN SUPPLIES-PAPER	3,784		1	2	0	0
5295	MEAL CREDIT	0		2	2	0	0
5310	LAUNDRY WAGES	52,478	55,093	4	1	0	0
5340	LAUNDRY SICK & VAC	2,615		4	1	0	0
5370	LAUNDRY REPLACEMENT	10,434	16,090	4	2	0	0
5380	LAUNDRY REIMBURSEMENT			4	3	0	0
5390	LAUNDRY SUPPLIES	5,656		4	2	0	0
5410	HOUSEKEEPING WAGES	98,346	100,990	3	1	0	0
5440	HOUSEKEEPING SICK & VAC	2,644		3	1	0	0
5480	HOUSEKEEPING SUPPLIES	18,923	43,034	3	2	0	0
5490	HOUSEKEEPING SUPPLIES-	24,111		3	2	0	0
6010	RN WAGES-MEDICARE		1,875,077	10	1	0	0
6020	RN WAGES-NON MEDICAR	482,904		10	1	0	0
6030	DON WAGES	81,043		10	1	0	0
6035	ADON	74,721		10	1	0	0
6040	RN SICK & VACATION	37,217		10	1	0	0
6110	LPN WAGES-MEDICARE	198,659		10	1	0	0
6120	LPN WAGES-NON MEDICAL	0		10	1	0	0
6130	LPN WAGES OTHER			10	1	0	0
6140	LPN SICK & VACATION	12,019		10	1	0	0
6210	AIDE WAGES-MEDICARE			10	1	0	0
6220	AIDE WAGES-NON MEDICAL	831,067		10	1	0	0
6230	WARD CLERKS			10	1	0	0
6240	AIDE VACATION & SICK	42,217		10	1	0	0
6245	CONTRACT NURSES-RN	0		10	3	0	0
6246	CONTRACT NURSES-LPN	0		10	3	0	0
6247	CONTRACT NURSES-AIDES	0		10	3	0	0
6250	NURSE AIDE TRAINING W/	0	0	13	1	0	0
6255	NURSE AID TRAINING EXP	0	0	13	2	0	0
6260	NURSE AIDE TRAINING RE	0		0	0	0	0
6270	REHAB WAGES	108,367		10	1	0	0
6275	REHAB SICK & VAC	6,863		10	1	0	0

6280	NURSING DEPT EDUCATION			23	3	0	0
6290	NURSING SUPPLIES	55,298	95,152	10	2	0	0
6295	NURSING SUPPLIES	2,843		10	2	0	0
6390	REPLACEMENT-NURSING	37,011		10	2	0	0
6490	NURSING OTHER	28,380	36,446	10	3	0	0
7280	DRUG PURCHASES	154,979	335,684	39	2	0	0 ***
7281	DRUG PURCHASES-OTHER	175,934		39	2		
7380	LABORATORY SERVICES	6,752	621,229	39	3	0	0
7410	HOME HEALTH SALARY			39	1	0	0
7440	HOME HEALTH SICK & VAC			39	1	0	0
7450	HOME HEALTH EXPENSES			39	3	0	0
7510	ACTIVITES WAGES	68,539	71,073	11	1	0	0
7540	ACTIVITIES SICK & VAC	2,534		11	1	0	0
7590	ACTIVITIES SUPPLIES	7,076	7,076	11	2	0	0
7595	ACTIVITIES FEES	0	0	11	3	0	0
7610	PT WAGES			39	1	0	0
7611	PT SICK & VACATION			39	1	0	0
7620	PT FEES	280,817		39	3	0	0 ***
7660	PT SUPPLIES	4,771		39	2	0	0
7710	SOCIAL SERVICE WAGES	37,928	38,855	12	1	0	0
7720	SOCIAL SERVICE SICK & V	927		12	1	0	0
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0
7740	OT FEE	273,628		39	3	0	0 ***
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0
7770	SPEECH THERAPY FEE	60,032		39	3	0	0 ***
7800	BEAUTICIAN WAGES		0	40	1	0	0
7810	BEAUTICIAN SICK & VAC			40	1	0	0
7820	BEAUTICIAN FEES	0	0	40	3	0	0
7890	BEAUTY SHOP SUPPLIES	108	108	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	411,720	411,720	34	3	0	0

8120	INTEREST EXPENSE	22,818	22,818	32	3	14	-2,196	
8130	DEPRECIATION	0	0	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	60,773
9510	INTEREST INCOME	-2,196		32	0	10	0	
9520	MISC NON-OPERATING INC	0		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	
		6,033,187	6,035,383					
			2,196					

GRAND TOTALS -133,558 -169,215  
(NET INCOME)

0

FACILITY NAME:

FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

G/L

RECAP CENSUS

PP 3,043

3,043

IPA 23,093

23,093

medicare 3,506

3,506

29,642

IPA BEDHOLDS 0

PP BEDHOLDS 0

PP CONVERS 0

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DEBT

#2

DEBT

3,007 3,007 PATIENT D 3,043

3,007	3,007 PATIENT D	23,093
3,007	3,007 PATIENT D	3,506
3,007		0
3,007		
3,007		
3,007		
3,010	3,010 BASIC CHA	(5,489,568)
3,020	3,020 BASIC CHA	0
3,030	3,030 BASIC CHA	0
3,040		0
3,050		0
3,060		0
3,061		0
3,080	3,080 NURSING S	(19,082)
3,081	3,081 NURSING S	0
3,082	3,082 NURSING S	0
3,083	3,083 NURSING S	0
3,100	3,100 DRUGS-ME	(598,832)
3,101		0
3,110	3,110 PHYSICAL S	(1,943,332)
3,111		0
3,112	3,112 PHYSICAL S	0
3,113	3,113 PHYSICAL S	0
3,140	3,140 LABORATORY INCOME	
3,150		0
3,151		
3,152	3,152 ST/OT THEF	0
3,153	3,153 ST/OT THEF	0
3,160	3,185 REHAB/ISOLATION/OTHER CHG	
3,410	3,410 IPA/OTHER	0
3,411	3,411 MEDICARE	0
3,420	3,420 MEDICARE	1,731,888
3,500		

3,520	3,520 RENT INCO	0
3,530	3,530 BEAUTY SE	0
3,560		0
3,570	3,570 VENDING II	118
3,590	3,590 EQUIPMENT	(1,434)
3,595	3,595 RESIDENT	0
3,600	3,600 MISC INCOI	0
4,110	4,110 G&A WAGE	222,148
4,111	4,111 ADMINISTR	101,880
4,115	4,115 G&A PTO &	11,976
4,120	4,120 EMPLOYEE	10,975
4,125		0
4,130	4,130 EMPLOYEE	0
4,135	4,135 EMPLOYEE	0
4,250	4,250 OFFICE SUP	17,375
4,255	4,255 POSTAGE	6,264
4,260	4,260 TELEPHONI	18,595
4,275	4,275 TRAINING &	4,646
4,276		0
4,280	4,280 GENERAL T	3,989
4,281	4,281 MEAL EXPE	66
4,285	4,285 EDUCATION	3,015
4,289	4,289 MEETINGS	0
4,290	4,290 HELP WAN	0
4,291	4,291 PROMOTIO	19,785
4,292	4,292 PUBLIC REI	21,082
4,300	4,300 LICENSE &	55,598
4,310	4,310 DUES & SU	7,450
4,320	4,320 CONTRIBU	0
4,350	4,350 PROFESSIO	13,809
4,355	4,355 MEDICAL E	12,000
4,362		2,426
4,363		5,640

4,364	4,364 SOCIAL SEI	3,614
4,370	4,370 TV RENTAL	21,063
4,383	4,383 BACKGROU	1,340
4,390	4,390 OTHER TAX	0
4,400	4,400 PAYROLL T	247,068
4,401	4,401 PAYROLL T	10,100
4,410	4,410 GROUP INS	241,224
4,420	4,420 LIABILITY I	66,735
4,430	4,430 WORKMAN	49,485
4,435	4,435 W/C-FIRST	384
4,436	4,436 DRUG TEST	315
4,450	4,450 MANAGEM	262,673
4,460	4,460 BAD DEBTS	99,980
4,461	4,461 BAD DEBTS	153,497
4,470	4,470 LOST ITEM	0
4,475	4,475 UNIFORM E	(582)
4,486	4,486 SERVICE CC	17,868
4,490	4,490 MISC EXPE	(84)
4,496	4,496 MISC. M.I.S.	7,693
4,510	4,510 REAL ESTA	0
4,600	4,600 LEASED EQ	564
5,110	5,110 MAINTENA	76,248
5,120	5,120 MAINTENA	5,518
5,130	5,130 ELECTRIC	64,904
5,131	5,131 NATURAL C	3,727
5,133	5,133 WATER & S	34,513
5,134	5,134 TRASH COL	10,204
5,140	5,140 PROP/PLAN	11,698
5,160	5,160 GENERAL F	38,845
5,165	5,165 MAINTENA	22,026
5,210	5,210 DIETARY W	243,135
5,220	5,220 DIETARY P	10,403
5,248	5,248 FOOD PURC	216,790

5,250	5,250 SUPPLIES D	2,534
5,260	5,260 REPLACEM	516
5,270	5,270 KITCHEN S	3,784
5,295	5,295 MEAL INCC	0
5,310	5,310 LAUNDRY V	52,478
5,340	5,340 LAUNDRY I	2,615
5,370	5,370 REPLACEM	10,434
5,380		0
5,390	5,390 SUPPLIES	5,656
5,410	5,410 HOUSEKEE	98,346
5,440	5,440 HOUSEKEE	2,644
5,480	5,480 SUPPLIES-C	18,923
5,490	5,490 SUPPLIES-E	24,111
6,020	6,020 RN WAGES	482,904
6,030	6,030 DON WAGE	81,043
6,035	6,035 ADON WAG	74,721
6,040	6,040 RN PTO & R	37,217
6,120	6,120 LPN WAGES	198,659
6,140	6,140 LPN PTO &	12,019
6,220	6,220 AIDES WAC	831,067
6,240	6,240 AIDES PTO	42,217
6,245		
6,246		0
6,247		
6,250		0
6,255		0
6,260		0
6,270	6,270 REHAB WA	108,367
6,275	6,275 REHAB PTC	6,863
6,290	6,290 NURSING S	55,298
6,295	6,295 NURSING S	2,843
6,390	6,390 REPLACEM	37,011
6,490	6,490 OTHER	28,380

7,280	7,280 DRUG PURC	154,979
7,281	7,281 DRUG PURC	175,934
7,380	7,380 LABORATO	2,987
7,391	7,390 X-RAY SER	3,491
7,393		274
7,510	7,510 ACTIVITIES	68,539
7,540	7,540 ACTIVITIES	2,534
7,590	7,590 ACTIVITIES	7,076
7,620	7,620 PHYSICAL	280,817
7,660	7,660 P.T. SUPPLY	4,771
7,710	7,710 SOCIAL SEF	37,928
7,720	7,720 SOCIAL SEF	927
7,730	7,730 SOCIAL SEF	0
7,740	7,740 OCCUPATIC	273,628
7,750		0
7,770	7,770 SPEECH TH	60,032
7,820	7,820 BEAUTICIA	0
7,890		108
7,960		0
8,120	8,120 INTEREST	0
8,125		22,818
8,130	8,130 DEPRECIAT	0
8,150		0
9,510	9,510 INTEREST I	(2,196)
9,520	9,520 MISC NON-C	0
9,530	4,220	0
	8,100	411,720
	9,702	0
	5,230	0
		<u>(133,558)</u>

Expenses Fixed Assets



FACILITY	MEDICAID NUMBER	STATE LICENSE NUMBER
<b>Owned SNFs</b>		
Heritage Health - South, IL	20-5300302001	48843
Heritage Health - Bloomington, IL	20-3904134001	48157
Heritage Health - Carlinville, IL	20-5508113001	48850
Heritage Health - Chillicothe, IL	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, IL	20-3902572001	48116
Heritage Health - Gillespie, IL	20-5428620001	48892
Heritage Health - LaSalle, IL	27-3741988001	51276
Heritage Health - Litchfield, IL	20-5508096001	48900
Heritage Health - Mendota, IL	20-3904038001	48108
Heritage Health - Minonk, IL	20-3903980001	48058
Heritage Health - Mt. Sterling, IL	20-3903543001	48041
Heritage Health - Mt. Zion, IL	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, IL	20-5437628001	48876
Heritage Health - Streator, IL	20-3902216001	48066
Barton W. Stone Jackson, IL	20-5298969002	48918
Danville Joint Ventures, IL	37-1357323001	42168
Heritage Health - Danville, IL	37-1359387001	41699
Cotillion Ridge, IL	37-1402726001	45138
Country Health - Danville, IL	37-6064916001	7880
Mason City Area, IL	37-1168043001	34256
St. Clara's Medical Center, IL	37-6075710001	50724
Vonderlieth, IL	37-0967671001	19976