

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0009530</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER											
Facility Name: <u>Harbor Crest Home, Inc.</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.											
Address: <u>817 17th Street</u> <u>Fulton</u> <u>61252</u>													
Number City Zip Code													
County: <u>Whiteside</u>													
Telephone Number: <u>(815) 589-3411</u> Fax # <u>(815) 589-4728</u>													
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Myra Chatic</u></td></tr><tr><td>(Title) <u>Adminstrator</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Patrick W. Parker, CPA Principal</u></td></tr><tr><td>(Firm Name & Address) <u>Winkel, Parker & Foster, CPA PC</u> <u>1301 19th Ave NW, Clinton, IA 52732</u></td></tr><tr><td>(Telephone) <u>(563) 242-3440</u> Fax # <u>(563) 242-5555</u></td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Myra Chatic</u>	(Title) <u>Adminstrator</u>	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Patrick W. Parker, CPA Principal</u>	(Firm Name & Address) <u>Winkel, Parker & Foster, CPA PC</u> <u>1301 19th Ave NW, Clinton, IA 52732</u>	(Telephone) <u>(563) 242-3440</u> Fax # <u>(563) 242-5555</u>	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
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Date of Initial License for Current Owners: <u>07/06/1966</u>													
Type of Ownership:													
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Facility Name & ID Number Harbor Crest Home, Inc.

0009530 Report Period Beginning: 01/01/11 Ending: 12/31/11

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	84	Intermediate (ICF)	84	30,660	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	84	TOTALS	84	30,660	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					8
9	SNF/PED					9
10	ICF	11,245	6,221		17,466	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,245	6,221		17,466	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.97%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

