

		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: 48082

Facility Name: Heritage Manor Normal, LLC.

Address: 509 N. Adelaide Normal 61761
Number City Zip Code

County: McLean

Telephone Number: (309) 452-7468 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: July 2006

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

x

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

x

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/11 to 12/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed)

(Type or Print Name) Craig Ater

(Title) Exec VP & CFO

Paid Preparer

(Signed)

(Print Name and Title)

(Firm Name & Address)

(Telephone) Fax # ()

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

Facility Name & ID Number Heritage Manor Normal, LLC.

48082 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	162	Skilled (SNF)	162	59,130	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	162	TOTALS	162	59,130	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	24,257	24,558	2,464	51,279	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,257	24,558	2,464	51,279	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.72%

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? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

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

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date July 2006 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 2,464

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: _____ Fiscal Year: _____
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Heritage Manor Normal, LLC. # 48082 Report Period Beginning: 01/01/11 Ending: 12/31/11
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	486,998	32,162		519,160		519,160	9,089	528,249			1
2	Food Purchase		366,245		366,245		366,245	31	366,276			2
3	Housekeeping	198,187	50,268		248,455		248,455	13	248,468			3
4	Laundry	142,359	29,676		172,035		172,035	9	172,044			4
5	Heat and Other Utilities			170,519	170,519		170,519	3,202	173,721			5
6	Maintenance	161,448	93,562	73,082	328,092		328,092	23,560	351,652			6
7	Other (specify):*											7
8	TOTAL General Services	988,992	571,913	243,601	1,804,506		1,804,506	35,904	1,840,410			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600	131	9,731			9
10	Nursing and Medical Records	3,032,970	190,661	17,830	3,241,461		3,241,461		3,241,461			10
10a	Therapy		482,876	641,318	1,124,194	(497,026)	627,168	223,057	850,225			10a
11	Activities	133,441	3,364		136,805		136,805		136,805			11
12	Social Services	65,515		5,076	70,591		70,591		70,591			12
13	CNA Training	12,897	2,316		15,213		15,213	1,304	16,517			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,244,823	679,217	673,824	4,597,864	(497,026)	4,100,838	224,492	4,325,330			16
	C. General Administration											
17	Administrative	86,972			86,972		86,972	138,308	225,280			17
18	Directors Fees											18
19	Professional Services			449,232	449,232		449,232	(432,700)	16,532			19
20	Dues, Fees, Subscriptions & Promotions			141,239	141,239	(89,790)	51,449	(4,723)	46,726			20
21	Clerical & General Office Expenses	369,028	32,148	8,699	409,875		409,875	305,163	715,038			21
22	Employee Benefits & Payroll Taxes			1,091,995	1,091,995		1,091,995	64,165	1,156,160			22
23	Inservice Training & Education			875	875		875	797	1,672			23
24	Travel and Seminar			4,778	4,778		4,778	(2,779)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			84,701	84,701		84,701	18,803	103,504			26
27	Other (specify):*			15,331	15,331		15,331	(14,480)	851			27
28	TOTAL General Administration	456,000	32,148	1,796,850	2,284,998	(89,790)	2,195,208	72,554	2,267,762			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,689,815	1,283,278	2,714,275	8,687,368	(586,816)	8,100,552	332,950	8,433,502			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							350,081	350,081			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,348	17,348		17,348	193,947	211,295			32
33	Real Estate Taxes							132,467	132,467			33
34	Rent-Facility & Grounds			718,320	718,320		718,320	(721,955)	(3,635)			34
35	Rent-Equipment & Vehicles			16,834	16,834		16,834	1,508	18,342			35
36	Other (specify):*											36
37	TOTAL Ownership			752,502	752,502		752,502	(43,952)	708,550			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					497,026	497,026		497,026			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					89,790	89,790		89,790			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers					586,816	586,816		586,816			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,689,815	1,283,278	3,466,777	9,439,870		9,439,870	288,998	9,728,868			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space	(5,180)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(3,058)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		23		16
17	Non-Care Related Fees	(787)	20		17
18	Fines and Penalties				18
19	Entertainment	(18,152)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,798)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,480)	27		24
25	Fund Raising, Advertising and Promotional	(12,895)	20		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)	\$ (61,350)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	350,348		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 350,348		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 288,998		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

ID#48082

Report Period Beginning:01/01/11

Ending:12/31/11

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		(787)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(6,798)	19	22
23				23
24		(14,480)	27	24
25		(12,895)	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	(34,960)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor Normal, LLC. # 48082 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	9,089	0	0	0	0	0	0	0	0	9,089	1
2	Food Purchase	0	0	31	0	0	0	0	0	0	0	0	31	2
3	Housekeeping	0	0	13	0	0	0	0	0	0	0	0	13	3
4	Laundry	0	0	9	0	0	0	0	0	0	0	0	9	4
5	Heat and Other Utilities	0	0	3,202	0	0	0	0	0	0	0	0	3,202	5
6	Maintenance	0	0	23,560	0	0	0	0	0	0	0	0	23,560	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	35,904	0	0	0	0	0	0	0	0	35,904	8
	B. Health Care and Programs													
9	Medical Director	0	0	131	0	0	0	0	0	0	0	0	131	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	223,057	0	0	0	0	0	0	0	0	0	223,057	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	1,304	0	0	0	0	0	0	0	0	1,304	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	223,057	1,435	0	0	0	0	0	0	0	0	224,492	16
	C. General Administration													
17	Administrative	0	0	138,308	0	0	0	0	0	0	0	0	138,308	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,798)	(442,434)	16,532	0	0	0	0	0	0	0	0	(432,700)	19
20	Fees, Subscriptions & Promotions	(13,682)	0	8,959	0	0	0	0	0	0	0	0	(4,723)	20
21	Clerical & General Office Expenses	0	0	305,163	0	0	0	0	0	0	0	0	305,163	21
22	Employee Benefits & Payroll Taxes	0	0	64,165	0	0	0	0	0	0	0	0	64,165	22
23	Inservice Training & Education	0	0	797	0	0	0	0	0	0	0	0	797	23
24	Travel and Seminar	(18,152)	0	15,373	0	0	0	0	0	0	0	0	(2,779)	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	18,803	0	0	0	0	0	0	0	0	18,803	26
27	Other (specify):*	(14,480)	0	0	0	0	0	0	0	0	0	0	(14,480)	27
28	TOTAL General Administration	(53,112)	(442,434)	568,100	0	0	0	0	0	0	0	0	72,554	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(53,112)	(219,377)	605,439	0	0	0	0	0	0	0	0	332,950	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor Normal, LLC. # 48082 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	330,993	0	19,088	0	0	0	0	0	0	0	350,081	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,058)	196,027	0	978	0	0	0	0	0	0	0	193,947	32
33	Real Estate Taxes	0	132,467	0	0	0	0	0	0	0	0	0	132,467	33
34	Rent-Facility & Grounds	(5,180)	(718,320)	0	1,545	0	0	0	0	0	0	0	(721,955)	34
35	Rent-Equipment & Vehicles	0	0	0	1,508	0	0	0	0	0	0	0	1,508	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(8,238)	(58,833)	0	23,119	0	0	0	0	0	0	0	(43,952)	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)	(61,350)	(278,210)	605,439	23,119	0	0	0	0	0	0	0	288,998	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Heritage Enterprises, Inc.	100	See Page 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$		1
2	V	10a	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	223,057	223,057	2
3	V								3
4	V	19	Adjustment for Related Organization	442,434	Heritage Operations Group, LLC	0.00%		(442,434)	4
5	V								5
6	V	34	Adjustment for Related Organization	718,320	Heritage Manor Real Estate, LLC	0.00%		(718,320)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		132,467	132,467	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		189,972	189,972	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		330,993	330,993	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		6,055	6,055	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,160,754			\$ 882,544	\$ * (278,210)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Heritage Enterprises, Inc.		\$	9,089	15
16	V	2	Food Purchase					31	16
17	V	3	Housekeeping					13	17
18	V	4	Laundry					9	18
19	V	5	Heat & Other Utilities					3,202	19
20	V	6	Maintenance					23,560	20
21	V	7	Other					0	21
22	V	9	Medical Director					131	22
23	V	10	Nursing & Medical Records					0	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					1,304	26
27	V	14	Program Transportation					0	27
28	V	15	Other					0	28
29	V	17	Administrative					138,308	29
30	V	18	Directors Fees					0	30
31	V	19	Professional Services					16,532	31
32	V	20	Fees, Subscription, Promotions					8,959	32
33	V	21	Clerical & General Office Expenses					305,163	33
34	V	22	Employee Benefits & Payroll Taxes					64,165	34
35	V	23	Inservice Training & Education					797	35
36	V	24	Travel and Seminar					15,373	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					18,803	38
39	Total			\$			\$	0	\$ * 605,439 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					19,088	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					978	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					1,545	20
21	V	35	Rent-Equipment & Vehicles					1,508	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	\$ * 23,119 39

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

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

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		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 Manor Normal, LLC. # 48082 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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 ☐

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	\$ 153,442	\$ 153,115	162	\$ 9,089	1
2	2	Food Purchase	Beds	2,735	26	520	0	162	31	2
3	3	Housekeeping	Beds	2,735	26	215	0	162	13	3
4	4	Laundry	Beds	2,735	26	151	0	162	9	4
5	5	Heat & Other Utilities	Beds	2,735	26	54,054	0	162	3,202	5
6	6	Maintenance	Beds	2,735	26	397,756	75,127	162	23,560	6
7	7	Other	Beds	2,735	26	0	0	162	0	7
8	9	Medical Director	Beds	2,735	26	2,206	0	162	131	8
9	10	Nursing & Medical Records	Beds	2,735	26	0	0	162	0	9
10	11	Activities	Beds	2,735	26	0	0	162	0	10
11	12	Social Service	Beds	2,735	26	0	0	162	0	11
12	13	Nurse Aide Training	Beds	2,735	26	22,009	20,793	162	1,304	12
13	14	Program Transportation	Beds	2,735	26	0	0	162	0	13
14	15	Other	Beds	2,735	26	0	0	162	0	14
15	17	Administrative	Beds	2,735	26	2,335,023	2,335,023	162	138,308	15
16	18	Directors Fees	Beds	2,735	26	0	0	162	0	16
17	19	Professional Services	Beds	2,735	26	279,109	0	162	16,532	17
18	20	Fees, Subscription, Promotions	Beds	2,735	26	151,258	0	162	8,959	18
19	21	Clerical & General Office Expenses	Beds	2,735	26	5,151,979	4,517,846	162	305,163	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,735	26	1,083,278	0	162	64,165	20
21	23	Inservice Training & Education	Beds	2,735	26	13,460	0	162	797	21
22	24	Travel and Seminar	Beds	2,735	26	259,533	0	162	15,373	22
23	25	Other Admin. Staff Transportation	Beds	2,735	26	0	0	162	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,735	26	317,454	0	162	18,803	24
25	TOTALS					\$ 10,221,447	\$ 7,101,904		\$ 605,439	25

Facility Name & ID Number Heritage Manor Normal, LLC. # 48082 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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 ☐

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	\$		162	\$	1
2	30	Depreciation	Beds	2,735	26	322,258		162	19,088	2
3	31	Amortization of Pre-Op & Org	Beds	2,735	26			162		3
4	32	Interest	Beds	2,735	26	16,517		162	978	4
5	33	Real Estate Taxes	Beds	2,735	26			162		5
6	34	Rent-Facility & Grounds	Beds	2,735	26	26,080		162	1,545	6
7	35	Rent-Equipment & Vehicles	Beds	2,735	26	25,461		162	1,508	7
8	36	Other	Beds	2,735	26			162		8
9	38	Medically Nec Transportation	Beds	2,735	26			162		9
10	39	Ancillary Service Centers	Beds	2,735	26			162		10
11	40	Barber and Beauty Shops	Beds	2,735	26			162		11
12	41	Coffee and Gift Shops	Beds	2,735	26			162		12
13	42	Other	Beds	2,735	26			162		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					\$ 390,316	\$		\$ 23,119	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE											
A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)											
	1	2		3	4	5	6	7	8	9	10
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO				Original	Balance			
	A. Directly Facility Related										
	Long-Term										
1	Bank of America		xx	Mortgage			\$	4,279,224	03/2016	variable	\$ 189,972 1
2	Bank of America		xx	Loan Fees							6,055 2
3											3
4											4
5											5
	Working Capital										
6	Bank of America		xx	Accounts Receivable							17,348 6
7											7
8											8
9	TOTAL Facility Related						\$	4,279,224			\$ 213,375 9
	B. Non-Facility Related*										
10	Interest Income										(3,058) 10
11	Allocated Corporate										978 11
12											12
13											13
14	TOTAL Non-Facility Related						\$				\$ (2,080) 14
15	TOTALS (line 9+line14)						\$	4,279,224			\$ 211,295 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.)

HFS 3745 (N-4-99)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 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.)		\$	132,467	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	132,467	3	
4. Real Estate Tax accrual used for 2011 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.		\$	132,467	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	94,949	8	
		2007	102,125	9	
		2008	103,961	10	
		2009	109,388	11	
		2010	132,467	12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2010 \$ 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.

FACILITY NAME	<u>Heritage Manor Normal, LLC.</u>	COUNTY	<u>McLean</u>
---------------	------------------------------------	--------	---------------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>ex Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>

B. Real Estate Tax Cost Allocations

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.)

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,164

B. General Construction Type: Exterior brickFrame woodNumber 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				\$ 60,687	1
2					2
3	TOTALS			\$ 60,687	3

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	162				\$ 1,860,193	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1979 Improvements			1979	66,917						9
10	1980 Improvements			1980	48,089						10
11	1981 Improvements			1981	17,747						11
12	1982 Improvements			1982	18,009						12
13	1983 Improvements			1983	19,892						13
14	1984 Improvements			1984	25,484						14
15	1985 Improvements			1985	531,851						15
16	1986 Improvements			1986	82,460						16
17	1987 Improvements			1987	17,447						17
18	1988 Improvements			1988	133,532						18
19	1989 Improvements			1989	39,555						19
20	1990 Improvements			1990	18,557						20
21	1991 Improvements			1991	5,776						21
22	1992 Improvements			1992	8,016						22
23	1993 Improvements			1993	188,048						23
24	1994 Improvements			1994	187,325						24
25	1995 Improvements			1995	10,664						25
26	A/C Basement Laundry			1996	6,741						26
27	Asphalt Repair			1996	21,401						27
28	Remodel/Painting			1996	1,912						28
29	Fire Alarm Repair/Replace			1996	8,069						29
30	Kitchen Floor/Backsplash			1996	1,395						30
31											31
32											32
33	C/O Allocation							19,088	19,088		33
34	Book Depreciation					300,514		300,514			34
35											35
36											36

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

See Page 12A, Line 70 for total

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

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

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

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		\$ 5,277,428	\$ 300,514		\$ 319,602	\$ 19,088		1
2	Alzheimers Addition-Materials	1999	1,913,384						2
3	Alzheimers Addition-Labor	1999	16,393						3
4	Alzheimers Addition-Professional Fees	1999	43,955						4
5	Ventalation System-Materials	1999	2,591						5
6	Remodel Resident Rooms--Materials	1999	96,197						6
7	Remodel Resident Rooms--Professional Fees	1999	350						7
8	Patio Replacement	1999	3,700						8
9	WAN Room Renovation	1999	3,230						9
10	ALTA Survey	1999	5,488						10
11	PANIC Hardware	1999	1,941						11
12	Roof Work	1999	4,844						12
13	Boiler Replacement	1999	11,219						13
14	Garage Door	1999	985						14
15	West End Renovations-Labor	1999	2,184						15
16	Assisted Living Professional Fees	1999	1,843						16
17									17
18	West Wing Outlets	2000	8,485						18
19	Alzheimer Unit Flooring	2000	5,631						19
20	Accordian Door and Installation	2000	9,600						20
21	Air conditioning Units (2)	2000	1,240						21
22	Exterior Door Replacement	2000	6,095						22
23	Air conditioner -- Dishroom	2000	12,041						23
24	HVAC temp Control	2000	16,220						24
25	Mop sink and faucet (2)	2000	3,377						25
26	Clinical Sink	2000	847						26
27	Eye Wash Stations	2000	2,566						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,451,834	\$ 300,514		\$ 319,602	\$ 19,088	\$	34

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

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		\$ 7,451,834	\$ 300,514		\$ 319,602	\$ 19,088		1
2	West End Renovations-Labor	2000	9,940						2
3	West End Renovations-material	2000	7,991						3
4	Capital Report Adjustments	2000	(2,985)						4
5	Boiler Repair	2001	7,921						5
6	Code Alert	2001	6,248						6
7	Painting & Wallpaper Hallway	2001	2,714						7
8	Condenser	2001	3,203						8
9	Fire System Repair	2001	2,269						9
10	Sign	2001	3,266						10
11	Water Heater	2001	4,797						11
12									12
13	Smoke Detector	2002	2,000						13
14	Fence	2002	2,400						14
15	Mixing Valve	2002	2,000						15
16	Bathroom Repairs	2002	10,179						16
17	Sprinkler System	2002	1,019						17
18	Computer Cable	2002	1,076						18
19	Boiler Pump	2002	5,000						19
20	A/C Unit	2002	2,750						20
21	Administrator Office Remodel	2002	4,534						21
22	Fire System Repair	2002	1,234						22
23	A/C Repair	2002	3,535						23
24	Flag & Flag Pole	2002	600						24
25	Elevator Repairs	2002	6,862						25
26	Code Alert	2002	975						26
27	Exhaust Fan	2002	1,350						27
28	Capital Report Adjustments	2002	(3,184)						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,539,528	\$ 300,514		\$ 319,602	\$ 19,088	\$	34

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

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		\$ 7,539,528	\$ 300,514		\$ 319,602	\$ 19,088		1
2	Fire System	2003	8,614						2
3	Flag Pole	2003							3
4	Security Door	2003	5,990						4
5	A/C Unit	2003	1,580						5
6	Condensing Unit	2003	1,137						6
7	Compressor	2003	2,067						7
8	Sewage Ejection	2003	17,028						8
9	A/C Unit	2003	1,628						9
10									10
11	Sewage Ejection	2004	12,312						11
12	A/C Unit	2004	1,175						12
13	Water Softener	2004	18,667						13
14	Exterior Referbish	2004	2,202						14
15	Boiler	2004	16,060						15
16									16
17	Boiler	2005	388						17
18	Nurses Station	2005	8,146						18
19	Smoke Detectors	2005	3,884						19
20	Windows	2005	6,146						20
21	Tempering Valve	2005	2,510						21
22	Sewage Ejection	2005	1,310						22
23	Ansul System	2005	2,320						23
24	Accelerator	2005	1,548						24
25	A/C Unit	2005	2,550						25
26	A/C Unit	2005	1,275						26
27	Sidewalk Replacement	2005	21,297						27
28	Capital Report Adjustment	2005	(22,995)						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,656,367	\$ 300,514		\$ 319,602	\$ 19,088	\$	34

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

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 12D, Carried Forward		\$ 7,656,367	\$ 300,514		\$ 319,602	\$ 19,088		1
2	A/C Unit	2006	5,900						2
3									3
4									4
5	Capital Report Adj	2007	(16,473)						5
6	Interior Door	2007	425						6
7	Generator	2007	16,165						7
8	Mixing valve	2007	1,955						8
9	Water pipe	2007	2,350						9
10	Water Heater	2007	27,451						10
11	Window	2007	906						11
12	AC Condensing Unit	2007	2,345						12
13	Flooring	2007	775						13
14									14
15	Handrails	2008	2,904						15
16	Grinder Pump	2008	2,566						16
17	Exterior Panting	2008	13,372						17
18	Dining Room Windows	2008	8,150						18
19	Dining Room Roof	2008	78,218						19
20	Driveway Improvements	2008	4,400						20
21	boiler	2008	5,680						21
22	Duct Replacement	2008	16,973						22
23	Carpet	2008	54,088						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)		\$ 7,884,517	\$ 300,514		\$ 319,602	\$ 19,088		34

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

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 12E, Carried Forward		\$ 7,884,517	\$ 300,514		\$ 319,602	\$ 19,088		1
2	Capital Report Adj	2009	(33,138)						2
3	Fire Alarm	2009	4,458						3
4	Air Handler	2009	7,544						4
5	Landscaping	2009	31,059						5
6	Sprinkler	2009	29,630						6
7	Gutter	2009	3,800						7
8	Dinning room windows	2009	2,280						8
9	Dinning room roof	2009	17,408						9
10	Parking lot surface	2009	87,268						10
11	Boiler	2009	7,625						11
12	Parapet Walls	2009	11,000						12
13	Water Main	2009	6,130						13
14	Nurse Call & Phone system	2009	297,156						14
15									15
16	Retaining wall	2010	21,000						16
17	Air Handler	2010	38,790						17
18	Carpet - Legacy care wing	2010	52,529						18
19	water Meter	2010	5,855						19
20									20
21	West Nurse's Station	2011	35,324						21
22	Sprinkler system	2011	295,806						22
23	Sewer pipe	2011	6,561						23
24	Air Compressor	2011	7,313						24
25	Flooring repair	2011	5,580						25
26	Air Handler	2011	21,534						26
27	Sign	2011	8,500						27
28	Dry pendent sprinkler	2011	48,620						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,904,149	\$ 300,514		\$ 319,602	\$ 19,088	\$	34

**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	\$1,313,380	\$30,479	\$30,479	\$		\$	71
72	Current Year Purchases	61,812						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,375,192	\$30,479	\$30,479	\$		\$	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	2	
	Reference	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)	\$10,340,028	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$330,993	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$350,081	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$19,088	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

**

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: \$16,834
- 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

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year EndingAnnual Rent
12. /2012\$
13. /2013\$
14. /2014\$

* 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.

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:	3. CLINICAL PORTION:
	IN-HOUSE PROGRAM	IN-HOUSE PROGRAM
	IN OTHER FACILITY	IN OTHER FACILITY
	COMMUNITY COLLEGE	HOURS PER CNA
	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		2,316		2,316
3	Classroom Wages (a)				
4	Clinical Wages (b)		12,897		12,897
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 15,213	\$	\$ 15,213
10	SUM OF line 9, col. 1 and 2 (e)	\$ 15,213			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 287,252			\$ 287,252	1
2	Licensed Speech and Language Development Therapist		hrs			3,001			3,001	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			336,136	779		336,915	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				482,097		482,097	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					14,929			14,929	13
14	TOTAL			\$		\$ 641,318	\$ 482,876		\$ 1,124,194	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 13,036	\$	1
2	Cash-Patient Deposits	18,974		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	856,510		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,545		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	48,296		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 965,361	\$	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)	\$ 965,361	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 350,422	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,974		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	485,518		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,390		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				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 856,304	\$	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)	\$ 856,304	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 109,057	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 965,361	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (141,555)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (141,555)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	250,612	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)	\$ 250,612	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)	\$ 109,057	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,965,371	1
2	Discounts and Allowances for all Levels	(2,075,667)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,889,704	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,914,686	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,914,686	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	267	12
13	Barber and Beauty Care	39	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	5,180	16
17	Sale of Drugs	859,963	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,175	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 868,624	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,058	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,058	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		14,410	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 14,410	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,690,482	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,804,506	31
32	Health Care	4,597,864	32
33	General Administration	2,284,998	33
	B. Capital Expense		
34	Ownership	752,502	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)*	\$ 9,439,870	40
41	Income before Income Taxes (line 30 minus line 40)**	250,612	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 250,612	43

* 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.

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	1,603	1,722	\$ 61,838	\$ 35.91	1
2	Assistant Director of Nursing	1,688	1,935	53,944	27.88	2
3	Registered Nurses	19,956	20,899	613,502	29.36	3
4	Licensed Practical Nurses	27,442	28,326	668,109	23.59	4
5	CNAs & Orderlies	129,730	135,184	1,617,341	11.96	5
6	CNA Trainees	1,100	1,100	12,897	11.72	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,075	1,075	18,236	16.96	8
9	Activity Director					9
10	Activity Assistants	12,541	12,807	133,441	10.42	10
11	Social Service Workers	4,421	4,738	65,515	13.83	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	44,538	45,781	486,998	10.64	15
16	Dishwashers					16
17	Maintenance Workers	13,948	14,479	161,448	11.15	17
18	Housekeepers	20,869	21,487	198,187	9.22	18
19	Laundry	13,293	13,686	142,359	10.40	19
20	Administrator	1,900	2,080	86,972	41.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,804	18,620	369,028	19.82	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)	311,908	323,919	\$ 4,689,815 *	\$ 14.48	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		9,600		36
37	Medical Records Consultant		1,700		37
38	Nurse Consultant				38
39	Pharmacist Consultant		9,840		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		5,076		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 26,216		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. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
Cindy Wegner			\$ 86,972	Workers' Compensation Insurance		\$ 134,130	IDPH License Fee		\$ 0		
				Unemployment Compensation Insurance		62,861	Advertising: Employee Recruitment		21,004		
				FICA Taxes		358,771	Health Care Worker Background Check				
				Employee Health Insurance		455,926	(Indicate # of checks performed _____)		3,140		
				Employee Meals			Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*		0			8,835		
TOTAL (agree to Schedule V, line 17, col. 1)				Other Benefits		80,307	Dues & Subscriptions		11,005		
(List each licensed administrator separately.)			\$ 86,972	Central Office Allocation		64,165	License & Fees		3,405		
B. Administrative - Other							Central Office Allocation		8,959		
Description			Amount				Less: Public Relations Expense		(8,835)		
			\$				Non-allowable advertising		(787)		
							Yellow page advertising	(			
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)				
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar***				
C. Professional Services											
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description		Amount		
Heritage Operations Group	Mgt		\$ 442,434			\$	Out-of-State Travel		\$		
			0								
			0								
							In-State Travel				
									3,065		
									19		
							Seminar Expense		1,694		
							Central Office		(2,779)		
Legal adj to Zero			6,798				Entertainment Expense	(			
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)				
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 449,232				TOTAL				
							\$ 1,999				

*** Attach copy of IMRF notifications**

****See instructions.**

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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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?

no

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

xx

NO

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

Heritage Manor Normal 38281 07/2006

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$89,790

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 benefit: on Schedule V.

\$0

Has any meal income been offset against related costs?

yes

Indicate the amount. \$

33,050

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

no

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

no

If YES, please indicate the amount of income earned from such a program during this reporting period. \$

c. What percent of all travel expense relates to transportation of nurses and patients?

100%

d. Have vehicle usage logs been maintained?

yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

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
- HFS 3745 (N-4-99)

IL478-2471

FACILITY		STATE
Owned SNFs		LICENSE NUMBER
Heritage Health - South, LLC		48843
Heritage Health - Bloomington, LLC		48157
Heritage Health - Carlinville, LLC		48850
Heritage Health - Chillicothe, LLC		48868
Heritage Health - Dwight, LLC		50492
Heritage Health - Elgin, LLC		48132
Heritage Health - El Paso, LLC		48124
Heritage Health - Gibson City, LLC		48116
Heritage Health - Gillespie, LLC		48892
Heritage Health - LaSalle, LLC		51276
Heritage Health - Litchfield, LLC		48900
Heritage Health - Mendota, LLC		48108
Heritage Health - Minonk, LLC		48058
Heritage Health - Mt. Sterling, LLC		48041
Heritage Health - Mt. Zion, LLC		48074
Heritage Health - Normal, LLC		48082
Heritage Health - Pana, LLC		48884
Heritage Health - Peru, LLC		48090
Heritage Health - Staunton, LLC		48876
Heritage Health - Streator, LLC		48066
Barton W. Stone Jacksonville, LLC		48918
Danville Joint Ventures, LLC d/b/aColonial Manor		42168
Heritage Health - Springfield		41699
Cotillion Ridge		45138
Country Health		7880
Mason City Area NH		34256
St. Clara's Manor		50724
Vonderlieth Living Center		19976