

		FOR BHF USE					

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2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 0007880

Facility Name: Country Health

Address: 2304 C R 3000 N Gifford 61847
Number City Zip Code

County: Champaign

Telephone Number: 217-568-7362 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: 1970

Type of Ownership:

xx

VOLUNTARY,NON-PROFIT

xx

Charitable Corp.

Trust

IRS Exemption Code 501 C 3

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:

Name: Daniel Curry Telephone Number: 309-823-7164

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 01/01/2025 to 12/31/2025 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) Daniel Curry

(Title) EVP & 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
2200 Churchill Rd.
Springfield, IL 62702-3406

Phone # (217) 782-1630

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	89	Skilled (SNF)	89	32,485
2		Skilled Pediatric (SNF/PED)		
3		Intermediate (ICF)		
4		Intermediate/DD		
5		Sheltered Care (SC)		
6		ICF/DD 16 or Less		
7	89	TOTALS	89	32,485

B. Census-For the entire report period.

1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment							
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total
				Medicaid Primary	Medicare Primary				
8	SNF	6,962	6,490	2,575	0	11,163	1,204	1,577	29,971
9	SNF/PED								
10	ICF								
11	ICF/DD								
12	SC								
13	DD 16 OR LESS								
14	TOTALS	6,962	6,490	2,575		11,163	1,204	1,577	29,971

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 92.26%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve 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 xx

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

I. On what date did you start providing long term care at this location? Date started 1970

J. Was the facility purchased or leased after January 1, 1978? YES Date NO xx

K. Was the facility certified for Medicare during the reporting year? YES xx NO If YES, enter certified beds. number of certified beds 89

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

MODIFIED

ACCRUAL xx CASH* CASH*

Is your fiscal year identical to your tax year? YES xx NO

Tax Year: Fiscal Year:

* All facilities other than governmental must report on the accrual basis.

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			259,998	259,998		259,998		259,998			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			89,994	89,994		89,994	(5,844)	84,150			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			66,495	66,495		66,495		66,495			35
36	Other (specify):*											36
37	TOTAL Ownership			416,487	416,487		416,487	(5,844)	410,643			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			365,107	365,107	176,695	541,802		541,802			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					505,884	505,884		505,884			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			365,107	365,107	682,579	1,047,686	</				

NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	Reference	
1	Political Action Committee Payments	\$ (7,743)	20
2	Other Expenses Related to Lobbying Activities		
3			
4			
5			
6			
7			
8			
9			
10			
11	(12,000)	27	
12	(5,844)	32	
13	(83,948)	27	
14	(16,626)	20	
15	(7,743)	20	
16	0	35	
17	(1,343)	27	
18	(60)	19	
19			
20			
21			
22			
23			
24			
25			
26			
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41			
42			
43			
44			
45			
46			
47			
48			
49	Total	(135,307)	

STATE OF ILLINOIS				Ownership Listing-1					
Country Health									
ID#		0007880							
Report Period Beginning:		01/01/2025		Heritage Operations Gr					
Ending:		12/31/2025		Country Health Inc.					
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)				Management					
-Owners of companies must be listed instead of company names.				Operator/Licensee	Building Co.	Co./Home Office			
-Names of trust beneficiaries must be listed.				Ownership Percentage	Ownership Percentage	Ownership Percentage			
First Name	M.I.	Last Name	Place of Residence City State	Ownership Percentage	Ownership Percentage	Ownership Percentage			
1		Country Health Inc.	Gifford IL	100.00000	100.00000				
2									
3		Heritage Operations Group L.L.C.							
4		Craig Hart Trust	Hudson IL			28.42000			
5		Joseph Warner Trust	Bloomington IL			4.00000			
6		Linda Hagi Trust	Bloomington IL			2.41000			
7		Janice Hart Trust	Streator IL			2.41000			
8		Timothy Jefferson	Champaign IL			16.10000			
9		Paul Jefferson	Bloomington IL			16.10000			
10		Robert Dickson Family Trust	Naples IL			1.28000			
11		Cheryl Lowney	Lincoln IL			0.77000			
12		Steven Wannemacher	Bloomington IL			1.85000			
13		Bruce Hart	Phoenix IL			7.30700			
14		Brian Hart	Lake Forest IL			7.30700			
15		Benjamin Hart Trust	Bloomington IL			7.30700			
16		Jerry Westwood Trust	Naples IL			1.			

Facility Name & ID Number Country Health # 0007880 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

	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
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	TOTALS					\$	\$		\$	25

