

Facility Name & ID Number Heritage Manor Bloomington LLC

48157 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	88	Skilled (SNF)	88	32,120	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	88	TOTALS	88	32,120	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,010	12,798	3,759	23,567	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,010	12,798	3,759	23,567	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.37%

D. How many bed reserve days during this year were paid by the Department?
0 (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

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 7/2006

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 88 and days of care provided 3,759

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 Bloomington LLC # 48157 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	241,999	13,168		255,167		255,167	3,462	258,629		1
2	Food Purchase		168,360		168,360		168,360		168,360		2
3	Housekeeping	88,974	30,622		119,596		119,596	5	119,601		3
4	Laundry	70,571	17,236		87,807		87,807	1	87,808		4
5	Heat and Other Utilities			102,143	102,143		102,143	1,332	103,475		5
6	Maintenance	104,263	67,936	96,442	268,641		268,641	20,315	288,956		6
7	Other (specify):*										7
8	TOTAL General Services	505,807	297,322	198,585	1,001,714		1,001,714	25,115	1,026,829		8
	B. Health Care and Programs										
9	Medical Director			15,828	15,828		15,828		15,828		9
10	Nursing and Medical Records	1,898,401	176,418	275,336	2,350,155		2,350,155	(21,019)	2,329,136		10
10a	Therapy		869,774	58,481	928,255	(927,924)	331		331		10a
11	Activities	66,148	3,254		69,402		69,402		69,402		11
12	Social Services	71,431		428	71,859		71,859		71,859		12
13	CNA Training							955	955		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,035,980	1,049,446	350,073	3,435,499	(927,924)	2,507,575	(20,064)	2,487,511		16
	C. General Administration										
17	Administrative	90,054			90,054		90,054		90,054		17
18	Directors Fees										18
19	Professional Services			410,996	410,996		410,996	(355,807)	55,189		19
20	Dues, Fees, Subscriptions & Promotions			226,549	226,549	(169,337)	57,212	(24,734)	32,478		20
21	Clerical & General Office Expenses	236,408	24,685	23,868	284,961		284,961	319,100	604,061		21
22	Employee Benefits & Payroll Taxes			507,006	507,006		507,006	43,146	550,152		22
23	Inservice Training & Education			13,440	13,440		13,440	(8,441)	4,999		23
24	Travel and Seminar			5,653	5,653		5,653	(654)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			38,249	38,249		38,249	10,409	48,658		26
27	Other (specify):* Lost resident items			12,500	12,500		12,500	(11,300)	1,200		27
28	TOTAL General Administration	326,462	24,685	1,238,261	1,589,408	(169,337)	1,420,071	(28,281)	1,391,790		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,868,249	1,371,453	1,786,919	6,026,621	(1,097,261)	4,929,360	(23,230)	4,906,130		29

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

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

Facility Name & ID Number

Heritage Manor Bloomington LLC

#48157

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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	
	D. Ownership											
30	Depreciation							579,994	579,994			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			45,124	45,124		45,124	154,064	199,188			32
33	Real Estate Taxes							89,239	89,239			33
34	Rent-Facility & Grounds			486,180	486,180		486,180	(480,874)	5,306			34
35	Rent-Equipment & Vehicles			19,467	19,467		19,467	6,779	26,246			35
36	Other (specify):*											36
37	TOTAL Ownership			550,771	550,771		550,771	349,202	899,973			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			811,266	811,266	927,924	1,739,190	(359,604)	1,379,586			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					169,337	169,337		169,337			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			811,266	811,266	1,097,261	1,908,527	(359,604)	1,548,923			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,868,249	1,371,453	3,148,956	7,388,658		7,388,658	(33,632)	7,355,026			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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,689)			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)				16
17	Non-Care Related Fees	(9,890)			17
18	Fines and Penalties				18
19	Entertainment	(7,892)			19
20	Contributions	(500)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,003)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,800)			24
25	Fund Raising, Advertising and Promotional	(31,924)			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)	\$ (68,698)		\$	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	
		Amount	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)	35,066		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 35,066		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (33,632)		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
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	
							52

Heritage Manor Bloomington LLC

ID# 48157

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
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		(6,003)	19	22
23				23
24		(10,800)	27	24
25		(31,924)	20	25
26				26
27		(500)	27	27
28				28
29				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	(49,227)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor Bloomington LLC# 48157

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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	3,462	0	0	0	0	0	0	0	0	3,462	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	5	0	0	0	0	0	0	0	0	5	3
4	Laundry	0	0	1	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	0	0	1,332	0	0	0	0	0	0	0	0	1,332	5
6	Maintenance	0	0	20,315	0	0	0	0	0	0	0	0	20,315	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	25,115	0	25,115	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(21,345)	326	0	0	0	0	0	0	0	0	(21,019)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	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	955	0	0	0	0	0	0	0	0	955	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	(21,345)	1,281	0	(20,064)	16							
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,003)	(364,492)	14,688	0	0	0	0	0	0	0	0	(355,807)	19
20	Fees, Subscriptions & Promotions	(31,924)	0	7,190	0	0	0	0	0	0	0	0	(24,734)	20
21	Clerical & General Office Expenses	0	0	319,100	0	0	0	0	0	0	0	0	319,100	21
22	Employee Benefits & Payroll Taxes	0	0	43,146	0	0	0	0	0	0	0	0	43,146	22
23	Inservice Training & Education	(9,890)	(34)	1,483	0	0	0	0	0	0	0	0	(8,441)	23
24	Travel and Seminar	(7,892)	0	7,238	0	0	0	0	0	0	0	0	(654)	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	10,409	0	0	0	0	0	0	0	0	10,409	26
27	Other (specify):*	(11,300)	0	0	0	0	0	0	0	0	0	0	(11,300)	27
28	TOTAL General Administration	(67,009)	(364,526)	403,254	0	(28,281)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(67,009)	(385,871)	429,650	0	(23,230)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor Bloomington LLC# 48157

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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	553,765	0	26,229	0	0	0	0	0	0	0	579,994	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,689)	154,227	0	1,526	0	0	0	0	0	0	0	154,064	32
33	Real Estate Taxes	0	89,239	0	0	0	0	0	0	0	0	0	89,239	33
34	Rent-Facility & Grounds	0	(486,180)	0	5,306	0	0	0	0	0	0	0	(480,874)	34
35	Rent-Equipment & Vehicles	0	0	0	6,779	0	0	0	0	0	0	0	6,779	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,689)	311,051	0	39,840	0	349,202	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	(359,604)	0	0	0	0	0	0	0	0	0	(359,604)	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	(359,604)	0	0	0	0	0	0	0	0	0	(359,604)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(68,698)	(434,424)	429,650	39,840	0	(33,632)	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	Attached Following This Page		Heritage Operations G	Bloomington	Mgmt. Services
				Green Tree Pharmacy	Minonk	Pharmacy

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	10 Adjustment for Related Organiza	\$	GreenTree Pharmacy		\$ (21,345)	\$	(21,345)	1
2	V	23 Adjustment for Related Organization		GreenTree Pharmacy		(34)		(34)	2
3	V	39 Adjustment for Related Organization		GreenTree Pharmacy		(359,604)		(359,604)	3
4	V	19 Adjustment for Related Organization	364,492	Heritage Operations Group, LLC				(364,492)	4
5	V								5
6	V	34 Adjustment for Related Organization	486,180	Heritage Manor Real Estate, LLC				(486,180)	6
7	V	33 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		89,239		89,239	7
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		139,867		139,867	8
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		553,765		553,765	9
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		14,360		14,360	10
11	V								11
12	V								12
13	V								13
14	Total		\$ 850,672			\$ 416,248	\$ *	(434,424)	14

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

Facility Name & ID Number Heritage Manor Bloomington LLC# 48157Report Period Beginning: 1/1/2017Ending: 12/31/2017

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 Operations Group		\$	\$	3,462	15	
16	V	2 Food Purchase						0	16	
17	V	3 Housekeeping						5	17	
18	V	4 Laundry						1	18	
19	V	5 Heat & Other Utilities						1,332	19	
20	V	6 Maintenance						20,315	20	
21	V	7 Other						0	21	
22	V	9 Medical Director						0	22	
23	V	10 Nursing & Medical Records						326	23	
24	V	11 Activities						0	24	
25	V	12 Social Service						0	25	
26	V	13 Nurse Aide Training						955	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						14,688	31	
32	V	20 Fees, Subscription, Promotions						7,190	32	
33	V	21 Clerical & General Office Expenses						319,100	33	
34	V	22 Employee Benefits & Payroll Taxes						43,146	34	
35	V	23 Inservice Training & Education						1,483	35	
36	V	24 Travel and Seminar						7,238	36	
37	V	25 Other Admin. Staff Transportation						0	37	
38	V	26 Insurance-Prop.Liab.Malpract						10,409	38	
39	Total		\$			\$	0	\$ *	429,650	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 Operations Group		\$	\$	0	15	
16	V	30 Depreciation						26,229	16	
17	V	31 Amortization of Pre-Op & Org						0	17	
18	V	32 Interest						1,526	18	
19	V	33 Real Estate Taxes						0	19	
20	V	34 Rent-Facility & Grounds						5,306	20	
21	V	35 Rent-Equipment & Vehicles						6,779	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	\$ *	39,840	39

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

Facility Name & ID Number Heritage Manor Bloomington LLC # 48157 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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.	Sole Member		100.00					\$	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 Bloomington LLC

48157

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

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 Heritage Operations Group
 Street Address Box 3188
 City / State / Zip Code Bloomington, IL 61701
 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	Dietary	Beds	2,578	26	\$ 101,433	\$ 109,431	88	\$ 3,462	1
2	2	Food Purchase	Beds	2,578	26	0	0	88	0	2
3	3	Housekeeping	Beds	2,578	26	145	0	88	5	3
4	4	Laundry	Beds	2,578	26	16	0	88	1	4
5	5	Heat & Other Utilities	Beds	2,578	26	39,021	0	88	1,332	5
6	6	Maintenance	Beds	2,578	26	595,139	73,623	88	20,315	6
7	7	Other	Beds	2,578	26	0	0	88	0	7
8	9	Medical Director	Beds	2,578	26	0	0	88	0	8
9	10	Nursing & Medical Records	Beds	2,578	26	9,542	8,241	88	326	9
10	11	Activities	Beds	2,578	26	0	0	88	0	10
11	12	Social Service	Beds	2,578	26	0	0	88	0	11
12	13	Nurse Aide Training	Beds	2,578	26	27,991	27,014	88	955	12
13	14	Program Transportation	Beds	2,578	26	0	0	88	0	13
14	15	Other	Beds	2,578	26	0	0	88	0	14
15	17	Administrative	Beds	2,578	26	0	0	88	0	15
16	18	Directors Fees	Beds	2,578	26	0	0	88	0	16
17	19	Professional Services	Beds	2,578	26	430,283	0	88	14,688	17
18	20	Fees, Subscription, Promotions	Beds	2,578	26	210,633	0	88	7,190	18
19	21	Clerical & General Office Expense	Beds	2,578	26	9,348,167	8,831,995	88	319,100	19
20	22	Employee Benefits & Payroll Tax	Beds	2,578	26	1,263,974	0	88	43,146	20
21	23	Inservice Training & Education	Beds	2,578	26	43,441	0	88	1,483	21
22	24	Travel and Seminar	Beds	2,578	26	212,053	0	88	7,238	22
23	25	Other Admin. Staff Transportatio	Beds	2,578	26	0	0	88	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,578	26	304,925	0	88	10,409	24
25	TOTALS					\$ 12,586,763	\$ 9,050,304		\$ 429,650	25

Facility Name & ID Number Heritage Manor Bloomington LLC

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Report Period Beginning:

1/1/2017

Ending: 2/31/2017

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 Heritage Operations Group
 Street Address Box 3188
 City / State / Zip Code Bloomington, IL 61701
 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	27	Other	Beds	2,578	26	\$	88	\$	1
2	30	Depreciation	Beds	2,578	26	768,393	88	26,229	2
3	31	Amortization of Pre-Op & Org	Beds	2,578	26		88		3
4	32	Interest	Beds	2,578	26	44,696	88	1,526	4
5	33	Real Estate Taxes	Beds	2,578	26		88		5
6	34	Rent-Facility & Grounds	Beds	2,578	26	155,453	88	5,306	6
7	35	Rent-Equipment & Vehicles	Beds	2,578	26	198,602	88	6,779	7
8	36	Other	Beds	2,578	26		88		8
9	38	Medically Nec Transportation	Beds	2,578	26		88		9
10	39	Ancillary Service Centers	Beds	2,578	26		88		10
11	40	Barber and Beauty Shops	Beds	2,578	26		88		11
12	41	Coffee and Gift Shops	Beds	2,578	26		88		12
13	42	Other	Beds	2,578	26		88		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					\$ 1,167,144	\$	\$ 39,840	25

Facility Name & ID Number Heritage Manor Bloomington LLC

48157

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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		x	Mortgage			\$	\$		\$ 139,867	1									
2	Bank of America		x	Loan Fee Amortization						14,360	2									
3											3									
4											4									
5											5									
Working Capital																				
6	Bank of America		x	Working Capital						45,124	6									
7											7									
8											8									
9	TOTAL Facility Related						\$	\$		\$ 199,351	9									
B. Non-Facility Related*																				
10	Interest Income									(1,689)	10									
11											11									
12	Allocated Corporate									1,526	12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ (163)	14									
15	TOTALS (line 9+line14)						\$	\$		\$ 199,188	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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

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 2016 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.)		\$	89,239	2
3. Under or (over) accrual (line 2 minus line 1).		\$	89,239	3
4. Real Estate Tax accrual used for 2017 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.		\$	89,239	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2012	81,153	8	
	2013	84,744	9	
	2014	86,147	10	
	2015	88,973	11	
	2016	89,239	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2016	\$	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 & ID Number Heritage Manor Bloomington LLC

48157

Report Period Beginning:

1/1/2017

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12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,544 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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an empty column. Rows include 1988 (\$116,576), 2010 (\$138,502), and a TOTALS row (\$255,078).

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	Accumulated Depreciation
4	88			\$ 560,548	\$		\$	\$
5				221,147				
6								
7								
8								
Improvement Type**								
9	1978 Improvements	1978		14,607				
10	1979 Improvements	1979		95,460				
11	1980 Improvements	1980		75,591				
12	1981 Improvements	1981		11,544				
13	1982 Improvements	1982		9,256				
14	1983 Improvements	1983		13,130				
15	1984 Improvements	1984		7,215				
16	1985 Improvements	1985		45,885				
17	1986 Improvements	1986		13,469				
18	1988 Improvements	1988		83,109				
19	1989 Improvements	1989		2,439				
20	1990 Improvements	1990		30,676				
21	1991 Improvements	1991		4,207				
22	1992 Improvements	1992		1,208				
23	1993 Improvements	1993		97,303				
24	1994 Improvements	1994		29,638				
25	1995 Improvements	1995		121,304				
26	BOILER	1996		17,850				
27	EXHAUST HOOD	1996		1,075				
28	CODE ALERT	1996		1,852				
29	PHONE SYSTEM	1996		2,339				
30	INTERIOR REMODEL	1996		103,103				
31								
32								
33								
34	C/O Allocation				26,229		26,229	
35	Book Depreciation				395,538		395,538	
36								

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Manor Bloomington LLC

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Report Period Beginning:

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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	Interior Rehab--paint, wallpaper, remodel facility	1997	\$ 211,945	\$		\$	\$	\$	37
38	Remodel Physical Therapy	1997	43,069						38
39	Disposal Unit--Kitchen	1997	1,439						39
40	Code Alert System	1997	1,997						40
41	Kitchen Remodel	1997	766						41
42									42
43	Code Alert/Nurse Call System	1998	3,654						43
44	Kitchen Remodel	1998	4,166						44
45	Remodel Physical Therapy	1998	1,813						45
46	Addition--Materials	1998	13,431						46
47	Addition--Professional Fees	1998	109,885						47
48									48
49	Addition--Materials	1999	1,155,066						49
50	Addition--Professional Fees	1999	22,035						50
51	Steam Table Hood	1999	3,821						51
52	ALTA Survey	1999	2,434						52
53	Dish Washing Area	1999	4,083						53
54	Sewage Pump	1999	2,492						54
55	Parking Lot Pavement	1999	6,743						55
56									56
57	Dayroom Light Fixtures	2000	6,189						57
58	Door Kickplates	2000	2,991						58
59	Storm windows	2000	4,011						59
60	Addition--Materials	2000	12,770						60
61	Addition--Professional Fees	2000	5,893						61
62	Roof Repair	2000	5,510						62
63	Adj to Capital Report	2000	(2,383)						63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,187,775	\$ 421,767		\$ 421,767	\$	\$	70

**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	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		\$ 3,187,775	\$ 421,767		\$ 421,767	\$	\$	1
2	Paging System	2001	2,456						2
3	Alarm Door/Lock	2001	1,950						3
4	Code Alert	2001	3,965						4
5	Electrical Wiring for A/C Unit	2001	1,805						5
6	Main Water Meter	2001	2,000						6
7	Valves Boiler Unit	2001	1,883						7
8									8
9	Smoke Detectors and Installation	2002	14,551						9
10	Mixing valve	2002	1,862						10
11	Main Corridor Rehab (Wallcovering)	2002	3,885						11
12	Floor Tile	2002	1,280						12
13	Kitchen	2002	957						13
14	Roof Repair	2002	5,283						14
15									15
16	Smoke Detectors and Installation	2003	5,970						16
17	Roof Replacement	2003	111,250						17
18	Sprinklers	2003	31,119						18
19	Parking Lot	2003	3,862						19
20	Ceramic Tile	2003	1,315						20
21	Compressor	2003	3,898						21
22	Wallpaper	2003	857						22
23	Maglock Keypad	2003	2,762						23
24	ANSUL Fire Surpression	2003	1,450						24
25	Fire Escape Remodel	2003	2,003						25
26	Adj to Capital Report	2003	(14,958)						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,379,180	\$ 421,767		\$ 421,767	\$	\$	34

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

Facility Name & ID Number Heritage Manor Bloomington LLC

48157

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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 12B, Carried Forward		\$ 3,379,180	\$ 421,767		\$ 421,767	\$	\$	1
2	Sewage Pump	2004	3,823						2
3	Nurses Station A/C	2004	1,478						3
4	Fire Alarm	2004	2,825						4
5	Sealcoat Parking Lot	2004	1,646						5
6	Storm Windows	2004	645						6
7	Window A/C (8)	2004	6,030						7
8	Ceiling Repairs	2004	4,011						8
9									9
10	Delayed Egress Latches	2005	12,431						10
11	Mixing valve	2005	1,360						11
12	Paint ceiling	2005	596						12
13	A/C	2005	2,153						13
14	Sidewalk	2005	2,100						14
15									15
16	Plumbing	2006	6,791						16
17	A/C -- Thru wall units	2006	6,900						17
18	Exterior Painting	2006	11,650						18
19	Compressor	2006	5,015						19
20	Condensing Unit	2006	4,902						20
21	Insinkerator	2006	2,350						21
22	Water Softener	2006	27,469						22
23	Basement De-watering	2006	3,750						23
24	Paint Kitchen	2006	1,820						24
25	Repair building	2006	1,199						25
26	Landscaping	2006	1,335						26
27	Pump Motor	2006	1,072						27
28	Mixing valve	2006	2,884						28
29	Adj to Capital Report	2006	(722)						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,494,693	\$ 421,767		\$ 421,767	\$	\$	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	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 12C, Carried Forward		\$ 3,494,693	\$ 421,767		\$ 421,767	\$	\$	1
2	Resident Rooms Remodel -- Paint and flooring	2007	13,957						2
3	Sprinkler	2007	1,152						3
4	Compressor	2007	4,006						4
5	Condensor	2007	2,250						5
6	Water Heater	2007	7,359						6
7	Therapy Room Remodel-- Paint & Flooring	2007	2,527						7
8	Window treatments	2007	583						8
9	Cooler	2007	642						9
10	Boiler	2007	4,803						10
11	Adj to Capital Report	2007	(8,178)						11
12	Heat/Cool Units	2008	5,420						12
13	Replace Fire Escape	2008	13,577						13
14	Schematic Design (Architect Fees) Facility Renovation	2008	26,038						14
15	Water Heater --Backflow	2008	4,926						15
16	Fire Alarm	2008	63,563						16
17	Water Heater	2008	6,057						17
18	Adj to Capital Report	2008	(19,981)						18
19	HVAC Unit	2009	7,035						19
20	Compressor	2009	4,658						20
21	HVAC Renovation: Boilers, ducts, hvac units & labor	2009	360,549						21
22	Windows	2009	148,790						22
23									23
24	HVAC Renovation: Boilers, ducts, hvac units & labor	2010	15,355						24
25	Architect, engineering fees	2010	87,978						25
26	trane compressor	2010	6,255						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,254,014	\$ 421,767		\$ 421,767	\$	\$	34

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

Facility Name & ID Number Heritage Manor Bloomington LLC

48157

Report Period Beginning:

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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 12D, Carried Forward		\$ 4,254,014	\$ 421,767		\$ 421,767	\$	\$	1
2									2
3	<u>Signage</u>	2011	9,969						3
4									4
5	<u>PT Addition 2010 & 2011 - Contracted Total</u>	2011	1,604,828						5
6	<u>PT Addition 2010 & 2011 - Capitalized Interest</u>	2011	7,278						6
7	<u>Renovation 2010 & 2011 - Contracted Total</u>	2011	2,381,723						7
8	<u>Renovation 2010 & 2011 - Capitalized Interest</u>	2011	15,565						8
9	<u>Renovation 2010 & 2011 - Third Party Costs:</u>								9
10	<u>Architect</u>	2011	44,486						10
11	<u>Asbestos</u>	2011	99,441						11
12	<u>Construction Certificate Consultant</u>	2011	6,150						12
13	<u>Elevator</u>	2011	4,000						13
14	<u>Engineer</u>	2011	9,238						14
15	<u>Landscaping</u>	2011	17,814						15
16	<u>Legal/Plan Review</u>	2011	12,720						16
17	<u>Plumbing</u>	2011	10,340						17
18	<u>Signage, Electric,HVAC & Supplies</u>	2011	4,352						18
19	<u>Sitework</u>	2011	3,795						19
20	<u>Technology</u>	2011	321,596						20
21	<u>Window Coverings</u>	2011	5,295						21
22									22
23	<u>PT Addition (Additional Costs) - Signage</u>	2012	2,213						23
24	<u>Renovation (Additional Costs)</u>								24
25	<u>Architect</u>	2012	749						25
26	<u>Asbestos</u>	2012	16,910						26
27	<u>Landscaping</u>	2012	70,935						27
28	<u>Plumbing</u>	2012	1,325						28
29	<u>Signage, Electric,HVAC & Supplies</u>	2012	6,275						29
30	<u>Technology</u>	2012	60,097						30
31	<u>Window Coverings</u>	2012	27,483						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,998,591	\$ 421,767		\$ 421,767	\$	\$	34

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

Facility Name & ID Number Heritage Manor Bloomington LLC

48157

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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 12E, Carried Forward		\$ 8,998,591	\$ 421,767		\$ 421,767	\$	\$	1
2									2
3	Nurse Master Console	2012	5,031						3
4									4
5	Replacement- sprinkler heads, floor tile & countertop-1 Rm.	2013	10,395						5
6									6
7	Elevator Power Unit Replacement	2013	11,425						7
8	Point of Care Kiosk Cabling	2013	7,985						8
9	Air conditioning units - new	2013	3,646						9
10									10
11	Final Charge - Elevator Power Replacement	2014	8,275						11
12	Install 9 PTAC Units	2014	3,834						12
13	Elevator Upgrades-Code Requirements	2014	10,153						13
14	Install Split Replacement Systems - Rooms 129 and 130	2014	18,566						14
15	Parking Lot Upgrades	2014	10,025						15
16	Replace Sewage Ejection Pump	2014	6,146						16
17									17
18	Install (6) PTAC units	2015	2,730						18
19	Replaced east dining room compressor	2015	3,685						19
20	Replace sewage ejection pump	2015	4,406						20
21									21
22	Install 5T condensing unit	2016	3,802						22
23									23
24	Replaced shower room floor	2017	4,993						24
25	Partial roof replacement	2017	23,889						25
26	Replaced hot water pump	2017	2,998						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,140,575	\$ 421,767		\$ 421,767	\$	\$	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	\$ 2,293,052	\$ 158,227	\$ 158,227	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,293,052	\$ 158,227	\$ 158,227	\$		\$	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)	\$ 11,688,705	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 579,994	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 579,994	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	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: None
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.	<u>/2018</u>	\$ _____
13.	<u>/2019</u>	\$ _____
14.	<u>/2020</u>	\$ _____

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: \$ 19,467 Description: Televisions and copiers

(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.

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>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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>2. <u>CLASSROOM PORTION:</u></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>3. <u>CLINICAL PORTION:</u></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			
		1	2	3	4
		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	TOTALS	\$	\$	\$	\$
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

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.)

	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	\$		\$ 398,278	\$		\$ 398,278	1
2	Licensed Speech and Language Development Therapist		hrs			93,926			93,926	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			319,062	331		319,393	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				869,443		869,443	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					58,481			58,481	13
14	TOTAL			\$		\$ 869,747	\$ 869,774		\$ 1,739,521	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2017**

(last day of reporting year)

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	\$ 400	\$	1
2	Cash-Patient Deposits	7,055		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	957,126		3
4	Supply Inventory (priced at FIFO)	12,753		4
5	Short-Term Investments			5
6	Prepaid Insurance	8,310		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(2,350,240)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (1,364,596)	\$	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)	\$ (1,364,596)	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 164,400	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,055		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	274,769		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,182		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	<u>Bed Tax</u>	19,752		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 469,158	\$	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)	\$ 469,158	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,833,754)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (1,364,596)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,868,594)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,868,594)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	34,840	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)	\$ 34,840	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)	\$ (1,833,754)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor Bloomington LLC

48157

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,722,348	1
2	Discounts and Allowances for all Levels	(3,739,376)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,982,972	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,730,177	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,730,177	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		12
13	Barber and Beauty Care	1,406	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,706,104	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,150	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,708,660	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,689	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,689	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,423,498	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,001,714	31
32	Health Care	3,435,499	32
33	General Administration	1,589,408	33
B. Capital Expense			
34	Ownership	550,771	34
C. Ancillary Expense			
35	Special Cost Centers	811,266	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)*	\$ 7,388,658	40
41	Income before Income Taxes (line 30 minus line 40)**	34,840	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 34,840	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Heritage Manor Bloomington LLC

48157

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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	1,923	2,024	\$ 82,065	\$ 40.55	1
2	Assistant Director of Nursing	1,804	1,899	61,494	32.38	2
3	Registered Nurses	13,405	14,110	460,739	32.65	3
4	Licensed Practical Nurses	15,373	16,182	412,714	25.50	4
5	CNAs & Orderlies	55,637	58,566	876,716	14.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	194	204	4,673	22.91	8
9	Activity Director					9
10	Activity Assistants	4,916	5,175	66,148	12.78	10
11	Social Service Workers	3,524	3,709	71,431	19.26	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,289	19,252	241,999	12.57	15
16	Dishwashers					16
17	Maintenance Workers	5,172	5,444	104,263	19.15	17
18	Housekeepers	7,301	7,686	88,974	11.58	18
19	Laundry	5,170	5,442	70,571	12.97	19
20	Administrator	1,748	1,840	90,054	48.94	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,591	9,043	236,408	26.14	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)	143,047	150,576	\$ 2,868,249 *	\$ 19.05	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	15,828		36
37	Medical Records Consultant	37,915		37
38	Nurse Consultant			38
39	Pharmacist Consultant	4,246		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	428		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 58,417		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 210,086		50
51	Licensed Practical Nurses	2,618		51
52	Certified Nurse Assistants/Aides	15,247		52
53	TOTAL (lines 50 - 52)	\$ 227,951		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
Susan Holifield			\$ 90,054	Workers' Compensation Insurance	\$ 54,597	IDPH License Fee	\$	
				Unemployment Compensation Insurance	24,344	Advertising: Employee Recruitment	14,521	
				FICA Taxes	219,421	Health Care Worker Background Check (Indicate # of checks performed _____)	6,112	
				Employee Health Insurance	177,603	Patient Background Checks		
				Employee Meals		PR	15,668	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	7,126	
				Other Benefits	31,041	License & Fees	1,243	
				Central Office Allocation	43,146	Central Office Allocation	7,190	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 90,054	TOTAL (agree to Schedule V, line 22, col.8)		\$ 550,152	TOTAL (agree to Sch. V, line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (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**	
B. Administrative - Other			Amount	Description	Line #	Amount	Description	Amount
Description			\$			\$	Out-of-State Travel	\$
							In-State Travel	4,944
								32
							Seminar Expense	677
								(654)
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 410,996				\$ 4,999	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Manor Bloomington LLC# 48157Report Period Beginning: 1/1/2017Ending: 12/31/2017**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. HCCI
- (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 Yrs
- (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 _____ 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. \$ 169,337
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? No 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? _____ Indicate the amount. \$ 5,362
- (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. \$ 0
- (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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. None Claimed
Attach invoices and a summary of services for all architect and appraisal fees

Heritage Manor - Bloomington
IDPH ID# 48157
HFS Cost Report - December 31, 2017
Schedule V - Column 5 Reclassifications

1. Schedule V - Line 10a to Line 39 - Reclassifications

<u>Line Item</u>		
Purchased Drugs and Medications	\$	869,443
Purchased Hospital Services		33,865
Purchased Laboratory Services		19,159
Purchased Radiology Services		<u>5,457</u>
Amount Reclassified to Line 39	\$	<u><u>927,924</u></u>

2. Schedule V - Line 20 to Line 42 - Reclassification

<u>Line Item</u>		
Provider Participation Fee - \$1.50	\$	48,180
Provider Assessment Fee - \$6.70		<u>121,157</u>
Amount Reclassified to Line 42		<u><u>169,337</u></u>