FOR BHF USE

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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: 0048116

Facility Name: Heritage Health Gibson City

Address: 620 E 1st Street (Number) Gibson City (City) 60936 (Zip Code)

County: Ford

Telephone Number: (217) 784-4257 **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: David M Underwood   Telephone Number: 309823-7135

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 1/1/2017 to 12/31/2017 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) (Date)

(Type or Print Name) David M Underwood

(Title) EVP/CFO

Paid Preparer

(Signed) (Date)

(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 Health Gibson City # 0048116 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	75	Skilled (SNF)	75	27,375	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	75	TOTALS	75	27,375	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	12,202	4,408	1,132	17,742	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,202	4,408	1,132	17,742	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.81%

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 [x]

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

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 [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 75 and days of care provided 1,132

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: ____________ Fiscal Year: ____________

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

Facility Name & ID Number: Heritage Health Gibson City # 0048116 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	181,403	8,046		189,449		189,449	2,951	192,400			1
2	Food Purchase		135,613		135,613		135,613		135,613			2
3	Housekeeping	51,779	23,123		74,902		74,902	4	74,906			3
4	Laundry	35,908	8,735		44,643		44,643		44,643			4
5	Heat and Other Utilities			45,286	45,286		45,286	1,135	46,421			5
6	Maintenance	61,246	58,679	52,622	172,547		172,547	17,314	189,861			6
7	Other (specify):*											7
8	**TOTAL General Services**	330,336	234,196	97,908	662,440		662,440	21,404	683,844			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,200,190	66,665	25,355	1,292,210		1,292,210	(11,932)	1,280,278			10
10a	Therapy		378,377	9,744	388,121	(387,389)	732		732			10a
11	Activities	43,182	1,910		45,092		45,092		45,092			11
12	Social Services	36,109		3,141	39,250		39,250		39,250			12
13	CNA Training							814	814			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,279,481	446,952	50,240	1,776,673	(387,389)	1,389,284	(11,118)	1,378,166			16
	C. General Administration											
17	Administrative	88,159			88,159		88,159		88,159			17
18	Directors Fees											18
19	Professional Services			191,105	191,105		191,105	(177,978)	13,127			19
20	Dues, Fees, Subscriptions & Promotions			167,207	167,207	(142,930)	24,277	(10,261)	14,016			20
21	Clerical & General Office Expenses	149,544	21,855	23,128	194,527		194,527	271,960	466,487			21
22	Employee Benefits & Payroll Taxes			331,742	331,742		331,742	36,772	368,514			22
23	Inservice Training & Education			4,940	4,940		4,940	59	4,999			23
24	Travel and Seminar			3,188	3,188		3,188	1,811	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			26,696	26,696		26,696	8,871	35,567			26
27	Other (specify):* Lost resident items			20,598	20,598		20,598	(20,400)	198			27
28	**TOTAL General Administration**	237,703	21,855	768,604	1,028,162	(142,930)	885,232	110,834	996,066			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,847,520	703,003	916,752	3,467,275	(530,319)	2,936,956	121,120	3,058,076			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		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
30	Depreciation							137,688	137,688			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,459	38,459		38,459	12,253	50,712			32
33	Real Estate Taxes							35,492	35,492			33
34	Rent-Facility & Grounds			328,500	328,500		328,500	(323,978)	4,522			34
35	Rent-Equipment & Vehicles			28,513	28,513		28,513	5,778	34,291			35
36	Other (specify):*											36
37	TOTAL Ownership			395,472	395,472		395,472	(132,767)	262,705			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			553,803	553,803	387,389	941,192	(79,120)	862,072			39
40	Barber and Beauty Shops			3,433	3,433		3,433		3,433			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					142,930	142,930		142,930			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			557,236	557,236	530,319	1,087,555	(79,120)	1,008,435			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,847,520	703,003	1,869,460	4,419,983		4,419,983	(90,767)	4,329,216			45

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

Facility Name & ID Number Heritage Health Gibson City # 0048116 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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				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	(8,620)			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	(1,171)			17
18	Fines and Penalties				18
19	Entertainment	(4,358)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,468)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(20,400)			24
25	Fund Raising, Advertising and Promotional	(16,389)			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)**	$ (52,406)		$	30

BHF USE ONLY

48		49		50		51		52	

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)	(38,361)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (38,361)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (90,767)		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

Heritage Health Gibson City

ID# 0048116

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		(1,468)	19	22
23				23
24		(20,400)	27	24
25		(16,389)	20	25
26				26
27		0	29	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	(38,257)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Gibson City # 0048116 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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	2,951	0	0	0	0	0	0	0	0	2,951	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	4	0	0	0	0	0	0	0	0	4	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,135	0	0	0	0	0	0	0	0	1,135	5
6	Maintenance	0	0	17,314	0	0	0	0	0	0	0	0	17,314	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	21,404	0	0	0	0	0	0	0	0	21,404	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	(12,210)	278	0	0	0	0	0	0	0	0	(11,932)	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	814	0	0	0	0	0	0	0	0	814	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	(12,210)	1,092	0	0	0	0	0	0	0	0	(11,118)	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	(1,468)	(189,028)	12,518	0	0	0	0	0	0	0	0	(177,978)	19
20	Fees, Subscriptions & Promotions	(16,389)	0	6,128	0	0	0	0	0	0	0	0	(10,261)	20
21	Clerical & General Office Expenses	0	0	271,960	0	0	0	0	0	0	0	0	271,960	21
22	Employee Benefits & Payroll Taxes	0	0	36,772	0	0	0	0	0	0	0	0	36,772	22
23	Inservice Training & Education	(1,171)	(34)	1,264	0	0	0	0	0	0	0	0	59	23
24	Travel and Seminar	(4,358)	0	6,169	0	0	0	0	0	0	0	0	1,811	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	8,871	0	0	0	0	0	0	0	0	8,871	26
27	Other (specify):*	(20,400)	0	0	0	0	0	0	0	0	0	0	(20,400)	27
28	**TOTAL General Administration**	(43,786)	(189,062)	343,682	0	0	0	0	0	0	0	0	110,834	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(43,786)	(201,272)	366,178	0	0	0	0	0	0	0	0	121,120	29

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	115,334	0	22,354	0	0	0	0	0	0	0	137,688	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,620)	19,573	0	1,300	0	0	0	0	0	0	0	12,253	32
33	Real Estate Taxes	0	35,492	0	0	0	0	0	0	0	0	0	35,492	33
34	Rent-Facility & Grounds	0	(328,500)	0	4,522	0	0	0	0	0	0	0	(323,978)	34
35	Rent-Equipment & Vehicles	0	0	0	5,778	0	0	0	0	0	0	0	5,778	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(8,620)	(158,101)	0	33,954	0	0	0	0	0	0	0	(132,767)	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	(79,120)	0	0	0	0	0	0	0	0	0	(79,120)	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	(79,120)	0	0	0	0	0	0	0	0	0	(79,120)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(52,406)	(438,493)	366,178	33,954	0	0	0	0	0	0	0	(90,767)	45

Facility Name & ID Number Heritage Health Gibson City # 0048116 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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. [x] 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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Adjustment for Related Organiza	$	GreenTree Pharmacy		$ (12,210)	$ (12,210)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy		(34)	(34)	2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy		(79,120)	(79,120)	3
4	V	19	Adjustment for Related Organization	189,028	Heritage Operations Group, LLC			(189,028)	4
5	V								5
6	V	34	Adjustment for Related Organization	328,500	Heritage Manor Real Estate, LLC			(328,500)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		35,492	35,492	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		17,816	17,816	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		115,334	115,334	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		1,757	1,757	10
11	V								11
12	V								12
13	V								13
14	Total			$ 517,528			$ 79,035	$ * (438,493)	14

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

Facility Name & ID Number Heritage Health Gibson City # 0048116 Report Period Beginning: 1/1/2017 Ending: 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. [x] 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		$	$ 2,951	15
16	V	2	Food Purchase					0	16
17	V	3	Housekeeping					4	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,135	19
20	V	6	Maintenance					17,314	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					278	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					814	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					12,518	31
32	V	20	Fees, Subscription, Promotions					6,128	32
33	V	21	Clerical & General Office Expenses					271,960	33
34	V	22	Employee Benefits & Payroll Taxes					36,772	34
35	V	23	Inservice Training & Education					1,264	35
36	V	24	Travel and Seminar					6,169	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					8,871	38
39	Total			$			$ 0	$ * 366,178	39

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

STATE OF ILLINOIS

Facility Name & ID Number Heritage Health Gibson City # 0048116 Report Period Beginning: 1/1/2017 Ending: 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. [x] 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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	$	Heritage Operations Group		$	$ 0	15
16	V	30	Depreciation					22,354	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					1,300	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					4,522	20
21	V	35	Rent-Equipment & Vehicles					5,778	21
22	V	36	Other						22
23	V	38	Medically Nec Transportation						23
24	V	39	Ancillary Service Centers						24
25	V	40	Barber and Beauty Shops						25
26	V	41	Coffee and Gift Shops						26
27	V	42	Other						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	$ * 33,954	39

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

Facility Name & ID Number Heritage Health Gibson City # 0048116 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	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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 Health Gibson City # 0048116 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 [x] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,578	26	$ 101,433	$ 109,431	75	$ 2,951	1
2	2	Food Purchase	Beds	2,578	26	0	0	75	0	2
3	3	Housekeeping	Beds	2,578	26	145	0	75	4	3
4	4	Laundry	Beds	2,578	26	16	0	75	0	4
5	5	Heat & Other Utilities	Beds	2,578	26	39,021	0	75	1,135	5
6	6	Maintenance	Beds	2,578	26	595,139	73,623	75	17,314	6
7	7	Other	Beds	2,578	26	0	0	75	0	7
8	9	Medical Director	Beds	2,578	26	0	0	75	0	8
9	10	Nursing & Medical Records	Beds	2,578	26	9,542	8,241	75	278	9
10	11	Activities	Beds	2,578	26	0	0	75	0	10
11	12	Social Service	Beds	2,578	26	0	0	75	0	11
12	13	Nurse Aide Training	Beds	2,578	26	27,991	27,014	75	814	12
13	14	Program Transportation	Beds	2,578	26	0	0	75	0	13
14	15	Other	Beds	2,578	26	0	0	75	0	14
15	17	Administrative	Beds	2,578	26	0	0	75	0	15
16	18	Directors Fees	Beds	2,578	26	0	0	75	0	16
17	19	Professional Services	Beds	2,578	26	430,283	0	75	12,518	17
18	20	Fees, Subscription, Promotions	Beds	2,578	26	210,633	0	75	6,128	18
19	21	Clerical & General Office Expense	Beds	2,578	26	9,348,167	8,831,995	75	271,960	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,578	26	1,263,974	0	75	36,772	20
21	23	Inservice Training & Education	Beds	2,578	26	43,441	0	75	1,264	21
22	24	Travel and Seminar	Beds	2,578	26	212,053	0	75	6,169	22
23	25	Other Admin. Staff Transportatio	Beds	2,578	26	0	0	75	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,578	26	304,925		75	8,871	24
25	TOTALS					$ 12,586,763	$ 9,050,304		$ 366,178	25

Facility Name & ID Number Heritage Health Gibson City # 0048116 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 x 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,578	26	$	$	75	$	1
2	30	Depreciation	Beds	2,578	26	768,393		75	22,354	2
3	31	Amortization of Pre-Op & Org	Beds	2,578	26			75		3
4	32	Interest	Beds	2,578	26	44,696		75	1,300	4
5	33	Real Estate Taxes	Beds	2,578	26			75		5
6	34	Rent-Facility & Grounds	Beds	2,578	26	155,453		75	4,522	6
7	35	Rent-Equipment & Vehicles	Beds	2,578	26	198,602		75	5,778	7
8	36	Other	Beds	2,578	26					8
9	38	Medically Nec Transportation	Beds	2,578	26					9
10	39	Ancillary Service Centers	Beds	2,578	26					10
11	40	Barber and Beauty Shops	Beds	2,578	26					11
12	41	Coffee and Gift Shops	Beds	2,578	26					12
13	42	Other	Beds	2,578	26					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	$		$ 33,954	25

Facility Name & ID Number Heritage Health Gibson City # 0048116 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			$	$			$ 17,816	1
2	Bank of America		x	Loan Fee Amortization							1,757	2
3												3
4												4
5												5
	Working Capital											
6	Bank of America		x	Working Capital							38,459	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 58,032	9
	B. Non-Facility Related*											
10	Interest Income										(8,620)	10
11												11
12	Allocated Corporate										1,300	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (7,320)	14
15	TOTALS (line 9+line14)						$	$			$ 50,712	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.)

Facility Name & ID Number Heritage Health Gibson City # 0048116 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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.

Description	Amount	Line
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.)	$ 35,492	2
3. Under or (over) accrual (line 2 minus line 1).	$ 35,492	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.	$ 35,492	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2012	33,358	8
2013	33,780	9
2014	34,956	10
2015	38,074	11
2016	35,492	12

FOR BHF USE ONLY

Line	Description	Amount	Line
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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Health Gibson City COUNTY Ford

FACILITY IDPH LICENSE NUMBER 0048116

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2016 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-11-11-479-017		$ 149.08	$ 149.00
2.	09-11-11-482-001		$ 35,343.40	$ 35,343.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 35,492.48	$ 35,492.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES x NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,300 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (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 [x] (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 [x] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Heritage Health Gibson City # 0048116 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 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	75		1979	1962	$ 815,350	$		$	$	$	4
5			1992	1992	912,769						5
6											6
7											7
8											8
	Improvement Type**										
9	1981 Improvements			1981	41,753						9
10	1982 Improvements			1982	6,437						10
11	1983 Improvements			1983	240						11
12	1984 Improvements			1984	873						12
13	1985 Improvements			1985	7,530						13
14	1986 Improvements			1986	20,979						14
15	1987 Improvements			1987	2,222						15
16	1988 Improvements			1988	2,452						16
17	1989 Improvements			1989	28,639						17
18	1990 Improvements			1990	99,326						18
19	1991 Improvements			1991	36,637						19
20	1993 Improvements			1993	40,838						20
21	1994 Improvements			1994	66,399						21
22	1995 Improvements			1995	1,060						22
23	WINDOW REPLACEMENTS			1996	25,247						23
24	WATER HEATER			1996	1,639						24
25	RESIDENT ROOM REMODEL/PAINTING			1996	7,584						25
26	Parking Lot			1998	12,299						26
27											27
28	Smoke Dampers			1999	5,256						28
29	Water Heater			1999	1,971						29
30	Garbage Disposal			1999	1,693						30
31	Heat/Cool compressor			1999	3,277						31
32	Smoke Dampers			2000	1,295						32
33											33
34	C/O Allocation					22,354		22,354			34
35	Book Depreciation					93,576		93,576			35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Health Gibson City # 0048116 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Temperature Control Unit	2001	$ 1,700	$		$	$	$	37
38	AC Replacement	2001	4,400						38
39	Smoke Detection System								39
40									40
41	Smoke Detection System	2002	1,775						41
42	Landscaping	2002	1,425						42
43	Fire Supression	2002	4,458						43
44	Water Heater	2002	2,396						44
45	Keypad Perimeter	2002	941						45
46	Sealcoat Parking Lot	2002	1,371						46
47	Garbage Disposal	2002	1,520						47
48	Hot Water Tank	2002	3,168						48
49	Rehab Hallway--Wallpaper/Paint	2002	14,442						49
50									50
51	Exterior Doors	2003	2,195						51
52	Roof Replacement	2003	28,555						52
53	Security Door	2003	1,116						53
54	Water Heater	2003	1,999						54
55	Water Tank	2003	1,836						55
56									56
57	HVAC unit	2004	5,247						57
58	Grease Trap	2004	1,903						58
59	Quarry Tile	2004	3,165						59
60	Parking Lot Sealcoat	2004	1,579						60
61	HVAC unit	2004	1,000						61
62	Sprinkler Leak	2004	1,854						62
63	Hot Water Boiler	2004	2,133						63
64	Corridor Remodel Material and Labor	2004	20,242						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,254,185	$ 115,930		$ 115,930	$	$	70

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

Facility Name & ID Number Heritage Health Gibson City # 0048116 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 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		$ 2,254,185	$ 115,930		$ 115,930	$	$	1
2	Oxygen Room	2005	2,005						2
3	Heat/Cool Unit	2005	17,228						3
4									4
5	Heat/Cool Units	2006	25,182						5
6	Door	2006	2,887						6
7	Heater	2006	1,078						7
8	Sidewalk	2006	3,500						8
9	Boiler	2006	1,427						9
10	Remodel TLC Unit --carpet, paint,	2006	27,516						10
11	Parking Lot sealer	2006	1,699						11
12	Drapes	2006	1,172						12
13	adjustments	2006	(7,711)						13
14	dishwasher motor	2007							14
15	Remodel TLC Unit --carpet, paint,	2007	2,996						15
16	Water Heater	2007	2,907						16
17	Grease Trap	2007							17
18	Water Softener	2007	12,285						18
19									19
20	Emergency Alarms	2008	36,893						20
21									21
22	Water Heater	2008	4,982						22
23	Exterior Painting	2008	9,720						23
24									24
25	Sprinkler System	2009	11,980						25
26	Water Heater	2009	4,503						26
27	Generator	2009	26,450						27
28									28
29	Water Heater	2010	3,750						29
30	Generator	2010	43,596						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,490,230	$ 115,930		$ 115,930	$	$	34

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

Facility Name & ID Number Heritage Health Gibson City # 0048116 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,490,230	$ 115,930		$ 115,930	$	$	1
2									2
3	Micromatic Scrubber	2011	3,932						3
4	Duro-Last Roofing	2001	9,600						4
5	Trane Rooftop Unit	2001	23,888						5
6									6
7	Water Heater	2012	3,808						7
8	Lighting Retrofit	2012	5,860						8
9									9
10	Doors	2013	4,698						10
11	Feezer Condensation Unit	2013	8,198						11
12									12
13	Replace Roof	2014	96,012						13
14	Replace Backwater Valve	2014	4,044						14
15									15
16	Installed water heater	2015	4,228						16
17	Replace generator control board	2015	3,385						17
18	Remodeled front entrance and lobby areas - new flooring,	2015	46,794						18
19	painting, cabinets and gables								19
20									20
21	Add new circuit panel	2016	3,160						21
22	Install hot water storage tank	2016	4,200						22
23									23
24	Installed water heater-laundry	2017	6,600						24
25	Replaced dry valve	2017	4,387						25
26	Replaced dry pendant	2017	18,847						26
27	Replaced softener resin	2017	3,800						27
28									28
29	Remodeled both east and west corridors with new paint,	2017	186,856						29
30	handrails, artwork and signage; installed new light fixtures and								30
31	painted all walls in the therapy gym and the RESTORE resident								31
32	rooms; remodeled bathrooms in same RESTORE and therapy rooms								32
33	with new drywall and reworked shower tile and drain slope								33
34	TOTAL (lines 1 thru 33)		$ 2,932,527	$ 115,930		$ 115,930	$	$	34

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

Facility Name & ID Number Heritage Health Gibson City # 0048116 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 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		$ 2,932,527	$ 115,930		$ 115,930	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,932,527	$ 115,930		$ 115,930	$	$	34

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

Facility Name & ID Number Heritage Health Gibson City # 0048116 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	$ 577,599	$ 15,538	$ 15,538	$		$	71
72	Current Year Purchases	40,794						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 618,393	$ 15,538	$ 15,538	$		$	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		2017 Dodge Grand Caravan	2016	$ 46,540	$ 6,220	$ 6,220	$		$	76
77										77
78										78
79										79
80	TOTALS			$ 46,540	$ 6,220	$ 6,220	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,597,460	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 137,688	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 137,688	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.

Facility Name & ID Number Heritage Health Gibson City # 0048116 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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.	/2018	$
13.	/2019	$
14.	/2020	$

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 [x] NO
16. Rental Amount for movable equipment: $ 28,513 Description: Mattresses, beds, copiers and televisions
    (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.

STATE OF ILLINOIS

Facility Name & ID Number Heritage Health Gibson City # 0048116 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - 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				
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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 314,563	$		$ 314,563	1
2	Licensed Speech and Language Development Therapist		hrs			27,178			27,178	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			212,062	732		212,794	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				377,645		377,645	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					9,744			9,744	13
14	TOTAL			$		$ 563,547	$ 378,377		$ 941,924	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Heritage Health Gibson City # 0048116 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,740	$	1
2	Cash-Patient Deposits	6,219		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	790,801		3
4	Supply Inventory (priced at FIFO)	11,673		4
5	Short-Term Investments			5
6	Prepaid Insurance	4,500		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(4,537,612)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (3,722,679)	$	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)**	$ (3,722,679)	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 51,819	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,219		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	187,589		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,719		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	Bed Tax	16,067		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 264,413	$	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)**	$ 264,413	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,987,092)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (3,722,679)	$	48

*(See instructions.)

Facility Name & ID Number **Heritage Health Gibson City** **#** **0048116** **Report Period Beginning:** **1/1/2017** **Ending:** **12/31/2017**

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,478,548)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,478,548)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(508,544)	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)**	$ (508,544)	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)**	$ (3,987,092)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Heritage Health Gibson City # 0048116 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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,238,291	1
2	Discounts and Allowances for all Levels	(1,463,629)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,774,662	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,416,030	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,416,030	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	4,438	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	706,281	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	551	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 711,270	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,620	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,620	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Activity Fund	857	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 857	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,911,439	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	662,440	31
32	Health Care	1,776,673	32
33	General Administration	1,028,162	33
	B. Capital Expense		
34	Ownership	395,472	34
	C. Ancillary Expense		
35	Special Cost Centers	557,236	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)***	$ 4,419,983	40
41	**Income before Income Taxes (line 30 minus line 40)****	(508,544)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (508,544)	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 Health Gibson City # 0048116 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	1,839	1,936	$ 72,648	$ 37.52	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	8,464	8,910	280,483	31.48	3
4	Licensed Practical Nurses	8,439	8,883	231,790	26.09	4
5	CNAs & Orderlies	37,369	39,336	615,269	15.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			0		8
9	Activity Director					9
10	Activity Assistants	2,373	2,498	43,182	17.29	10
11	Social Service Workers	1,670	1,758	36,109	20.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,228	14,977	181,403	12.11	15
16	Dishwashers					16
17	Maintenance Workers	3,502	3,686	61,246	16.62	17
18	Housekeepers	5,108	5,377	51,779	9.63	18
19	Laundry	2,134	2,246	35,908	15.99	19
20	Administrator	1,801	1,896	88,159	46.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,257	5,534	149,544	27.02	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)	92,184	97,037	$ 1,847,520 *	$ 19.04	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		12,000		36
37	Medical Records Consultant		2,332		37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,201		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,141		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 20,674		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses		2,272		51
52	Certified Nurse Assistants/Aides		17,550		52
53	TOTAL (lines 50 - 52)		$ 19,822		53

Facility Name & ID Number Heritage Health Gibson City # 0048116 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Amanda Gronsky			$ 88,159
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 88,159

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Operations Group	Mgmt	$ 189,421
ADP	Payroll Tax Processing	216
Legal adj to Zero		1,468
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 191,105

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 46,636
Unemployment Compensation Insurance	12,198
FICA Taxes	141,335
Employee Health Insurance	112,702
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	18,871
Central Office Allocation	36,772
TOTAL (agree to Schedule V, line 22, col.8)	$ 368,514

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,553
Health Care Worker Background Check (Indicate # of checks performed)	1,476
Patient Background Checks	
PR	8,803
Dues & Subscriptions	5,127
License & Fees	752
Central Office Allocation	6,128
Less: Public Relations Expense	(8,803)
Non-allowable advertising	(3,020)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,016

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	2,197
	0
Seminar Expense	991
	1,811
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,999

**See instructions.

Facility Name & ID Number **Heritage Health Gibson City** **# 0048116** **Report Period Beginning: 1/1/2017 Ending: 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. $ **142,930**
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. $ **1,836**

(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 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 - Gibson City
HFS ID# 48116
HFS Cost Report - December 31, 2017
Schedule V - Column 5 Reclassifications

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

Line Item		
Purchased Drugs and Medications	$	377,645
Purchased Hospital Services		4,077
Purchased Laboratory Services		3,440
Purchased Radiology Services		2,227
Amount Reclassified to Line 39	$	387,389

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

Line Item		
Provider Participation Fee - $1.50	$	41,063
Provider Assessment Fee - $6.70		101,867
Amount Reclassified to Line 42		142,930