



Facility Name & ID Number Heritage Manor Normal LLC

# 0048157 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	141	Skilled (SNF)	141	51,465	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	141	TOTALS	141	51,465	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	18,722	20,488	2,963	42,173	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,722	20,488	2,963	42,173	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.95%

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 141 and days of care provided 2,963

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCURAL  MODIFIED CASH\*  CASH\*

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

Tax Year: \_\_\_\_\_ Fiscal Year: \_\_\_\_\_

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

Facility Name & ID Number Heritage Manor Normal LLC # 0048157 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

**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
	<b>A. General Services</b>										
1	Dietary	410,440	24,833	7,560	442,833		442,833	5,691	448,524		1
2	Food Purchase		292,679		292,679		292,679	74	292,753		2
3	Housekeeping	205,920	44,627		250,547		250,547		250,547		3
4	Laundry	94,740	27,192		121,932		121,932	6	121,938		4
5	Heat and Other Utilities			138,539	138,539		138,539	2,066	140,605		5
6	Maintenance	115,882	150,607	158,589	425,078		425,078	31,234	456,312		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	826,982	539,938	304,688	1,671,608		1,671,608	39,071	1,710,679		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			14,860	14,860		14,860		14,860		9
10	Nursing and Medical Records	3,387,530	225,504	271,026	3,884,060		3,884,060	(30,332)	3,853,728		10
10a	Therapy		487,072	56,757	543,829	(541,733)	2,096		2,096		10a
11	Activities	93,300	4,269		97,569		97,569		97,569		11
12	Social Services	82,229		2,586	84,815		84,815		84,815		12
13	CNA Training	2,614	532		3,146		3,146	1,635	4,781		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,565,673	717,377	345,229	4,628,279	(541,733)	4,086,546	(28,697)	4,057,849		16
	<b>C. General Administration</b>										
17	Administrative	93,965			93,965		93,965		93,965		17
18	Directors Fees										18
19	Professional Services			514,763	514,763		514,763	(479,275)	35,488		19
20	Dues, Fees, Subscriptions & Promotions			371,755	371,755	(313,703)	58,052	(17,121)	40,931		20
21	Clerical & General Office Expenses	466,605	28,599	13,781	508,985		508,985	499,934	1,008,919		21
22	Employee Benefits & Payroll Taxes			985,477	985,477		985,477	65,208	1,050,685		22
23	Inservice Training & Education			3,622	3,622		3,622	1,377	4,999		23
24	Travel and Seminar			4,695	4,695		4,695	304	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			58,070	58,070		58,070	35,165	93,235		26
27	Other (specify):* <b>100% Lost item - resident</b>			76,055	76,055		76,055	(71,756)	4,299		27
28	<b>TOTAL General Administration</b>	560,570	28,599	2,028,218	2,617,387	(313,703)	2,303,684	33,836	2,337,520		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,953,225	1,285,914	2,678,135	8,917,274	(855,436)	8,061,838	44,210	8,106,048		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 Normal LLC

#0048157

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

## 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	
	<b>D. Ownership</b>											
30	Depreciation							521,904	521,904			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			82,023	82,023		82,023	155,500	237,523			32
33	Real Estate Taxes							107,911	107,911			33
34	Rent-Facility & Grounds			718,320	718,320		718,320	(709,671)	8,649			34
35	Rent-Equipment & Vehicles			50,782	50,782		50,782	8,757	59,539			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			851,125	851,125		851,125	84,401	935,526			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			759,468	759,468	541,733	1,301,201	234,270	1,535,471			39
40	Barber and Beauty Shops			28,466	28,466		28,466		28,466			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					313,703	313,703		313,703			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			787,934	787,934	855,436	1,643,370	234,270	1,877,640			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,953,225	1,285,914	4,317,194	10,556,333		10,556,333	362,881	10,919,214			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 Manor Normal LLC

# 0048157

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

**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	(11,971)			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	(1,000)			17
18	Fines and Penalties	(6,500)			18
19	Entertainment	(10,185)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,813)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(65,256)			24
25	Fund Raising, Advertising and Promotional	(30,737)			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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (133,462)		\$	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)	496,343		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 496,343		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 362,881		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	
							52

Heritage Manor Normal LLC

ID# 0048157

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

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		0	30	22
23		(7,813)	19	23
24		(65,256)	27	24
25		(30,737)	20	25
26		(10,185)	24	26
27		(6,500)	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	<b>Total</b>	(120,491)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor Normal LLC# 0048157

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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

	Operating Expenses	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)	
	<b>A. General Services</b>													
1	Dietary	0	0	5,691	0	0	0	0	0	0	0	0	5,691	1
2	Food Purchase	0	0	74	0	0	0	0	0	0	0	0	74	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	6	0	0	0	0	0	0	0	0	6	4
5	Heat and Other Utilities	0	0	2,066	0	0	0	0	0	0	0	0	2,066	5
6	Maintenance	0	0	31,234	0	0	0	0	0	0	0	0	31,234	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	39,071	0	0	0	0	0	0	0	0	39,071	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(31,243)	911	0	0	0	0	0	0	0	0	(30,332)	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	1,635	0	0	0	0	0	0	0	0	1,635	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	<b>TOTAL Health Care and Programs</b>	0	(31,243)	2,546	0	0	0	0	0	0	0	0	(28,697)	16
	<b>C. General Administration</b>													
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	(7,813)	(495,588)	24,126	0	0	0	0	0	0	0	0	(479,275)	19
20	Fees, Subscriptions & Promotions	(30,737)	0	13,616	0	0	0	0	0	0	0	0	(17,121)	20
21	Clerical & General Office Expenses	0	0	499,934	0	0	0	0	0	0	0	0	499,934	21
22	Employee Benefits & Payroll Taxes	0	0	65,208	0	0	0	0	0	0	0	0	65,208	22
23	Inservice Training & Education	(1,000)	(72)	2,449	0	0	0	0	0	0	0	0	1,377	23
24	Travel and Seminar	(10,185)	0	10,489	0	0	0	0	0	0	0	0	304	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	35,165	0	0	0	0	0	0	0	0	35,165	26
27	Other (specify):*	(71,756)	0	0	0	0	0	0	0	0	0	0	(71,756)	27
28	<b>TOTAL General Administration</b>	(121,491)	(495,660)	650,987	0	0	0	0	0	0	0	0	33,836	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(121,491)	(526,903)	692,604	0	0	0	0	0	0	0	0	44,210	29

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor Normal LLC# 0048157

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	0	482,106	0	39,798	0	0	0	0	0	0	0	521,904	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,971)	167,471	0	0	0	0	0	0	0	0	0	155,500	32
33	Real Estate Taxes	0	107,911	0	0	0	0	0	0	0	0	0	107,911	33
34	Rent-Facility & Grounds	0	(718,320)	0	8,649	0	0	0	0	0	0	0	(709,671)	34
35	Rent-Equipment & Vehicles	0	0	0	8,757	0	0	0	0	0	0	0	8,757	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(11,971)</b>	<b>39,168</b>	<b>0</b>	<b>57,204</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>84,401</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	234,270	0	0	0	0	0	0	0	0	0	234,270	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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>234,270</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>234,270</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(133,462)</b>	<b>(253,465)</b>	<b>692,604</b>	<b>57,204</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>362,881</b>	<b>45</b>



**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
<u>Heritage Enterprises, Inc.</u>	<u>100</u>	<u>Attached Following This Page</u>		<u>Heritage Operations G</u>	<u>Bloomington</u>	<u>Mgmt. Services</u>
				<u>Green Tree Pharmacy</u>	<u>Minonk</u>	<u>Pharmacy</u>

**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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	<u>10 Adjustment for Related Organization</u>	\$	<u>GreenTree Pharmacy</u>		\$ <u>(31,243)</u>	\$	<u>(31,243)</u> 1
2	V	<u>23 Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>		<u>(72)</u>		<u>(72)</u> 2
3	V	<u>39 Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>		<u>234,270</u>		<u>234,270</u> 3
4	V	<u>19 Adjustment for Related Organization</u>	<u>495,588</u>	<u>Heritage Operations Group, LLC</u>				<u>(495,588)</u> 4
5	V							5
6	V	<u>34 Adjustment for Related Organization</u>	<u>718,320</u>	<u>Heritage Manor Real Estate, LLC</u>				<u>(718,320)</u> 6
7	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>107,911</u>		<u>107,911</u> 7
8	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>115,823</u>		<u>115,823</u> 8
9	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>482,106</u>		<u>482,106</u> 9
10	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>51,648</u>		<u>51,648</u> 10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		\$ <b>1,213,908</b>			\$ <b>960,443</b>	\$ *	<b>(253,465)</b> 14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Heritage Operations Group		\$	\$ 5,691	15
16	V	2 Food Purchase		Heritage Operations Group			74	16
17	V	3 Housekeeping		Heritage Operations Group			0	17
18	V	4 Laundry		Heritage Operations Group			6	18
19	V	5 Heat & Other Utilities		Heritage Operations Group			2,066	19
20	V	6 Maintenance		Heritage Operations Group			31,234	20
21	V	7 Other		Heritage Operations Group			0	21
22	V	9 Medical Director		Heritage Operations Group			0	22
23	V	10 Nursing & Medical Records		Heritage Operations Group			911	23
24	V	11 Activities		Heritage Operations Group			0	24
25	V	12 Social Service		Heritage Operations Group			0	25
26	V	13 Nurse Aide Training		Heritage Operations Group			1,635	26
27	V	14 Program Transportation		Heritage Operations Group			0	27
28	V	15 Other		Heritage Operations Group			0	28
29	V	17 Administrative		Heritage Operations Group			0	29
30	V	18 Directors Fees		Heritage Operations Group			0	30
31	V	19 Professional Services		Heritage Operations Group			24,126	31
32	V	20 Fees, Subscription, Promotions		Heritage Operations Group			13,616	32
33	V	21 Clerical & General Office Expenses		Heritage Operations Group			499,934	33
34	V	22 Employee Benefits & Payroll Taxes		Heritage Operations Group			65,208	34
35	V	23 Inservice Training & Education		Heritage Operations Group			2,449	35
36	V	24 Travel and Seminar		Heritage Operations Group			10,489	36
37	V	25 Other Admin. Staff Transportation		Heritage Operations Group			0	37
38	V	26 Insurance-Prop.Liab.Malpract		Heritage Operations Group			35,165	38
39	Total		\$			\$	0	\$ * 692,604 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		Heritage Operations Group			39,798	16
17	V	31 Amortization of Pre-Op & Org		Heritage Operations Group			0	17
18	V	32 Interest		Heritage Operations Group			0	18
19	V	33 Real Estate Taxes		Heritage Operations Group			0	19
20	V	34 Rent-Facility & Grounds		Heritage Operations Group			8,649	20
21	V	35 Rent-Equipment & Vehicles		Heritage Operations Group			8,757	21
22	V	36 Other		Heritage Operations Group			0	22
23	V	38 Medically Nec Transportation		Heritage Operations Group			0	23
24	V	39 Ancillary Service Centers		Heritage Operations Group			0	24
25	V	40 Barber and Beauty Shops		Heritage Operations Group			0	25
26	V	41 Coffee and Gift Shops		Heritage Operations Group			0	26
27	V	42 Other		Heritage Operations Group			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	\$ * 57,204 39

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

Facility Name & ID Number Heritage Manor Normal LLC # 0048157 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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.			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 Normal LLC

# 0048157

Report Period Beginning:

1/1/2018

Ending: 2/31/2018

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

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	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	\$ 104,045	\$ 103,180	141	\$ 5,691	1
2	2	Food Purchase	Beds	2,578	26	1,362	0	141	74	2
3	3	Housekeeping	Beds	2,578	26	0	0	141	0	3
4	4	Laundry	Beds	2,578	26	111	0	141	6	4
5	5	Heat & Other Utilities	Beds	2,578	26	37,778	0	141	2,066	5
6	6	Maintenance	Beds	2,578	26	571,069	80,581	141	31,234	6
7	7	Other	Beds	2,578	26	0	0	141	0	7
8	9	Medical Director	Beds	2,578	26	0	0	141	0	8
9	10	Nursing & Medical Records	Beds	2,578	26	16,650	12,036	141	911	9
10	11	Activities	Beds	2,578	26	0	0	141	0	10
11	12	Social Service	Beds	2,578	26	0	0	141	0	11
12	13	Nurse Aide Training	Beds	2,578	26	29,896	28,423	141	1,635	12
13	14	Program Transportation	Beds	2,578	26	0	0	141	0	13
14	15	Other	Beds	2,578	26	0	0	141	0	14
15	17	Administrative	Beds	2,578	26	0	0	141	0	15
16	18	Directors Fees	Beds	2,578	26	0	0	141	0	16
17	19	Professional Services	Beds	2,578	26	441,112	0	141	24,126	17
18	20	Fees, Subscription, Promotions	Beds	2,578	26	248,958	0	141	13,616	18
19	21	Clerical & General Office Expense	Beds	2,578	26	9,140,644	8,773,931	141	499,934	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,578	26	1,192,239	0	141	65,208	20
21	23	Inservice Training & Education	Beds	2,578	26	44,777	0	141	2,449	21
22	24	Travel and Seminar	Beds	2,578	26	191,781	0	141	10,489	22
23	25	Other Admin. Staff Transportation	Beds	2,578	26	0	0	141	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,578	26	642,946	0	141	35,165	24
25	TOTALS					\$ 12,663,368	\$ 8,998,151		\$ 692,604	25

Facility Name & ID Number Heritage Manor Normal LLC

# 0048157

Report Period Beginning:

1/1/2018

Ending: 2/31/2018

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	\$	141	\$	1
2	30	Depreciation	Beds	2,578	26	727,658	141	39,798	2
3	31	Amortization of Pre-Op & Org	Beds	2,578	26		141		3
4	32	Interest	Beds	2,578	26		141		4
5	33	Real Estate Taxes	Beds	2,578	26		141		5
6	34	Rent-Facility & Grounds	Beds	2,578	26	158,134	141	8,649	6
7	35	Rent-Equipment & Vehicles	Beds	2,578	26	160,109	141	8,757	7
8	36	Other	Beds	2,578	26		141		8
9	38	Medically Nec Transportation	Beds	2,578	26		141		9
10	39	Ancillary Service Centers	Beds	2,578	26		141		10
11	40	Barber and Beauty Shops	Beds	2,578	26		141		11
12	41	Coffee and Gift Shops	Beds	2,578	26		141		12
13	42	Other	Beds	2,578	26		141		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					\$ 1,045,901	\$	\$ 57,204	25

Facility Name & ID Number

Heritage Manor Normal LLC

# 0048157

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Busey Bank		x	Mortgage			\$	\$		\$ 115,823	1									
2	Busey Bank		x	Loan Fee Amortization						51,648	2									
3											3									
4											4									
5											5									
<b>Working Capital</b>																				
6	Busey Bank		x	Working Capital						82,023	6									
7											7									
8											8									
9	<b>TOTAL Facility Related</b>						\$	\$		\$ 249,494	9									
<b>B. Non-Facility Related*</b>																				
10	Interest Income									(11,971)	10									
11											11									
12											12									
13											13									
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$ (11,971)	14									
15	<b>TOTALS (line 9+line14)</b>						\$	\$		\$ 237,523	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 Manor Normal LLC# 0048157

Report Period Beginning:

1/1/2018

Ending:

12/31/2018**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2017 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.)				\$	107,911 2
3. Under or (over) accrual (line 2 minus line 1).				\$	107,911 3
4. Real Estate Tax accrual used for 2018 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>				\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	107,911 7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2013	101,933	8		
	2014	102,557	9		
	2015	103,841	10		
	2016	106,738	11		
	2017	107,911	12		
				<b>FOR BHF USE ONLY</b>	
				13	FROM R. E. TAX STATEMENT FOR 2017 \$ 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.**



**2017 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Heritage Manor Normal LLC COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0048157

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 2017 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 2017.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-29-227-016</u>	_____	\$ <u>148,589.18</u>	\$ <u>107,911.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>148,589.18</u></u>	\$ <u><u>107,911.00</u></u>

**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? x YES \_\_\_\_\_ 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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 51,164 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).

Adelaide Apts - Independent Living - No shared services but real estate taxes shown on same bill

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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>181,333</u>	1
2					2
3	<b>TOTALS</b>			\$ <u>181,333</u>	3

**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	Adjustments	Accumulated Depreciation
4	141			\$ 1,860,193	\$		\$	\$	\$
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	1979 Improvements		1979	66,917					
10	1980 Improvements		1980	48,089					
11	1981 Improvements		1981	17,747					
12	1982 Improvements		1982	18,009					
13	1983 Improvements		1983	19,892					
14	1984 Improvements		1984	25,484					
15	1985 Improvements		1985	531,851					
16	1986 Improvements		1986	82,460					
17	1987 Improvements		1987	17,447					
18	1988 Improvements		1988	133,532					
19	1989 Improvements		1989	39,555					
20	1990 Improvements		1990	18,557					
21	1991 Improvements		1991	5,776					
22	1991 Improvements		1992	8,016					
23	1993 Improvements		1993	188,048					
24	1994 Improvements		1994	187,325					
25	1995 Improvements		1995	10,664					
26	1996 Improvements		1996	39,518					
27	1997 Improvements		1997	25,427					
28	1998 Improvements		1998	1,932,921					
29	1999 Improvements		1999	2,108,304					
30	2000 Improvements		2000	81,048					
31	2001 Improvements		2001	30,418					
32	2002 Improvements		2002	42,330					
33									
34	C/O Allocation				39,798		39,798		
35	Book Depreciation				374,949		374,949		
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 &amp; ID Number Heritage Manor Normal LLC

# 0048157

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

**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	2003 Improvements	2003	\$ 38,044	\$		\$	\$	\$	37
38	2004 Improvements	2004	50,416						38
39	2005 Improvements	2005	28,379						39
40	2006 Improvements	2006	5,900						40
41	2007 Improvements	2007	35,899						41
42	2008 Improvements	2008	186,351						42
43	2009 Improvements	2009	472,220						43
44	2010 Improvements	2010	118,174						44
45	2011 Improvements	2011	429,238						45
46	2012 Improvements	2012	217,692						46
47									47
48	Facility Remodel	2013	733,810						48
49	Parking Lot Addition	2013	19,834						49
50	Smoke Detectors	2013	5,567						50
51	Boiler Adjustments	2013	3,515						51
52	Pneumatic Adjustment - Radiator	2013	5,212						52
53	Elevator Door Restrictor	2013	3,150						53
54									54
55	Sanitary Line Repair	2014	5,470						55
56	Completion of 2013 Facility Remodel - final carpeting								56
57	plumbing and flooring upgrades to all patient rooms	2014	360,614						57
58									58
59	Retube boiler	2015	15,200						59
60	New flooring - soiled utility room	2015	6,472						60
61	Compressor replacement	2015	3,861						61
62	Replacement split system for laundry room	2015	6,725						62
63	Replaced failed LCD annunciator	2015	3,910						63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 10,295,181	\$ 414,747		\$ 414,747	\$	\$	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	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		\$ 10,295,181	\$ 414,747		\$ 414,747	\$	\$	1
2									2
3	Install new air compressor	2016	3,082						3
4	Upgrade elevator - installation of new alarms, lights	2016	10,330						4
5	pit ladder and phone								5
6	EIFS repairs to front car port and north side of building	2016	7,850						6
7									7
8	Replace old boiler	2017	252,610						8
9	Remove and replace stairwell flooring	2017	8,567						9
10	Added data lines for new offices and for point of care	2017	6,589						10
11	clinical system								11
12									12
13	Replace water softener system	2018	8,379						13
14	Replace compressor - walk in cooler	2018	4,835						14
15	Replace roof top AC unit - East dining area	2018	14,665						15
16	New compressors - commons area	2018	5,401						16
17	Replace generator panel - RTU	2018	7,907						17
18	Replace hot water coil and air handler	2018	4,985						18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,630,381	\$ 414,747		\$ 414,747	\$	\$	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	\$ 2,021,620	\$ 106,249	\$ 106,249	\$		\$	71
72	Current Year Purchases	38,354						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,059,974	\$ 106,249	\$ 106,249	\$		\$	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		2009 Ford Van	2009	\$ 42,960	\$ 908	\$ 908	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 42,960	\$ 908	\$ 908	\$		\$	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)	\$ 12,914,648	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 521,904	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 521,904	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.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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: \$ 50,782 Description: Bariatric beds, 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.

**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		532		532
3	Classroom Wages (a)				
4	Clinical Wages (b)		2,614		2,614
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 3,146	\$	\$ 3,146
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$	3,146		

- (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.

**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)	_____
<b>TOTAL TRAINED</b>	_____

- (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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist		hrs	\$		\$	396,317	\$		\$	396,317					1
2	Licensed Speech and Language Development Therapist		hrs				114,644				114,644					2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs				248,507		2,096		250,603					4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescripts						484,976		484,976					9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify):						56,757				56,757					13
14	TOTAL			\$		\$	816,225	\$	487,072	\$	1,303,297					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 Manor Normal LLC

# 0048157

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 400	\$	1
2	Cash-Patient Deposits	17,807		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,326,006		3
4	Supply Inventory (priced at FIFO )	18,784		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,603		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,326,309)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 38,291	\$	10
	<b>B. Long-Term Assets</b>			
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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 38,291	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 207,187	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,807		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	417,372		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,362		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
	<b>Other Current Liabilities(specify):</b>			
36	Bed Tax	19,976		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 679,704	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 679,704	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (641,413)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 38,291	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(310,566)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(310,566)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(330,847)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(330,847)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(641,413)</b>	<b>24</b> *

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

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

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

1			
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,930,459	1
2	Discounts and Allowances for all Levels	(3,109,548)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,820,911	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,438,808	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,438,808	8
<b>C. Other Operating Revenue</b>			
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	37,040	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	916,708	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	48	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 953,796	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	11,971	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 11,971	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 10,225,486	30

2			
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,671,608	31
32	Health Care	4,628,279	32
33	General Administration	2,617,387	33
<b>B. Capital Expense</b>			
34	Ownership	851,125	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	787,934	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,556,333	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(330,847)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (330,847)	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	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$	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 Normal LLC**

# **0048157**

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

**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	1,791	1,906	\$ 82,858	\$ 43.47	1
2	Assistant Director of Nursing	5,424	5,770	185,290	32.11	2
3	Registered Nurses	17,011	18,097	648,750	35.85	3
4	Licensed Practical Nurses	28,118	29,913	866,501	28.97	4
5	CNAs & Orderlies	97,585	103,814	1,570,216	15.13	5
6	CNA Trainees	270	287	2,614	9.11	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,921	2,044	33,915	16.59	8
9	Activity Director					9
10	Activity Assistants	7,108	7,561	93,300	12.34	10
11	Social Service Workers	3,728	3,966	82,229	20.73	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	31,169	33,158	410,440	12.38	15
16	Dishwashers					16
17	Maintenance Workers	7,064	7,515	115,882	15.42	17
18	Housekeepers	17,292	18,396	205,920	11.19	18
19	Laundry	7,617	8,104	94,740	11.69	19
20	Administrator	1,955	2,080	93,965	45.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,370	18,479	466,605	25.25	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)	245,423	261,090	\$ 4,953,225 *	\$ 18.97	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	\$ 7,560		35
36	Medical Director	14,860		36
37	Medical Records Consultant	1,167		37
38	Nurse Consultant			38
39	Pharmacist Consultant	7,502		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	2,586		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 33,675		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 166,628		50
51	Licensed Practical Nurses	70,761		51
52	Certified Nurse Assistants/Aides	22,186		52
53	TOTAL (lines 50 - 52)	\$ 259,575		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Dianne Cochran</u>			\$ <u>93,965</u>	<u>Workers' Compensation Insurance</u>	\$ <u>63,260</u>	<u>IDPH License Fee</u>	\$	
				<u>Unemployment Compensation Insurance</u>	<u>23,215</u>	<u>Advertising: Employee Recruitment</u>	<u>10,982</u>	
				<u>FICA Taxes</u>	<u>378,922</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>458,922</u>	<u>(Indicate # of checks performed )</u>	<u>7,338</u>	
				<u>Employee Meals</u>		<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>PR</u>	<u>15,383</u>	
				<u>Other Benefits</u>	<u>61,158</u>	<u>Dues &amp; Subscriptions</u>	<u>12,314</u>	
				<u>Central Office Allocation</u>	<u>65,208</u>	<u>License &amp; Fees</u>	<u>2,956</u>	
						<u>Central Office Allocation</u>	<u>13,616</u>	
						<u>Less: Public Relations Expense</u>	<u>(15,383)</u>	
						<u>Non-allowable advertising</u>	<u>(6,275)</u>	
						<u>Yellow page advertising</u>	<u>( )</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			\$ <u>93,965</u>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>	\$ <u>1,050,685</u>	<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>	\$ <u>40,931</u>	
<b>(List each licensed administrator separately.)</b>								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$ <u>0</u>			\$	<u>Out-of-State Travel</u>	\$
							<u>In-State Travel</u>	
								<u>2,727</u>
								<u>0</u>
							<u>Seminar Expense</u>	<u>1,968</u>
								<u>304</u>
							<u>Entertainment Expense</u>	<u>( )</u>
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			\$	<b>TOTAL</b>		\$	<b>TOTAL (agree to Sch. V, line 24, col. 8)</b>	\$ <u>4,999</u>
<b>(Attach a copy of any management service agreement)</b>								
C. Professional Services								
Vendor/Payee	Type		Amount					
<u>Heritage Operations Group</u>	<u>Management</u>		\$ <u>501,854</u>					
<u>Indeed Inc</u>	<u>Search firm</u>		<u>5,096</u>					
<u>Legal adj to Zero</u>			<u>7,813</u>					
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			\$ <u>514,763</u>					
<b>(For legal fee disclosure, see page 39 of instructions)</b>								

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name &amp; ID Number Heritage Manor Normal LLC

# 0048157

Report Period Beginning:

1/1/2018

Ending: 12/31/2018

**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. Health Care Council of Illinois
- (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. \$ 313,703  
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 benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 31,223
- (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: May Cocagne & King
- (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 - Normal  
IDPH ID# 48157  
HFS Cost Report - December 31, 2018  
Schedule V - Column 5 Reclassifications

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

<u>Line Item</u>	
Purchased Drugs and Medications	\$ 484,976
Purchased Hospital Services	20,226
Purchased Laboratory Services	24,950
Purchased Radiology Services	11,581
Amount Reclassified to Line 39	<u>\$ 541,733</u>

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

<u>Line Item</u>	
Provider Participation Fee - \$1.50	\$ (77,198)
Provider Assesment Fee - \$6.07	<u>(236,505)</u>
	<u>(313,703)</u>
Provider Participation Fee - Line 42	<u>313,703</u>