FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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: 0045138

Facility Name: COTILLION RIDGE NURSING CENTER

Address: 600 EAST ROBINWOOD DRIVE (Number) ROBINSON (City) 62454 (Zip Code)

County: Crawford

Telephone Number: (618) 544-3192 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: 2000

Type of Ownership:

	VOLUNTARY,NON-PROFIT	xx	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		xx	Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-01-10 to 12-31-10 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) Craig L. Ater
(Title) Exec V.P. & 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 COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	73	Skilled (SNF)	73	26,645	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	73	TOTALS	73	26,645	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,962	10,485	3,063	24,510	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,962	10,485	3,063	24,510	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.99%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 2000

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 _____ and days of care provided 3,063

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [xx] 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 COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

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	170,503	18,861		189,364		189,364	2,909	192,273			1
2	Food Purchase		163,327		163,327		163,327	(687)	162,640			2
3	Housekeeping	91,480	19,722		111,202		111,202		111,202			3
4	Laundry	48,374	9,645		58,019		58,019		58,019			4
5	Heat and Other Utilities			77,518	77,518		77,518	1,257	78,775			5
6	Maintenance	46,704	47,465	57,767	151,936		151,936	8,662	160,598			6
7	Other (specify):*											7
8	**TOTAL General Services**	357,061	259,020	135,285	751,366		751,366	12,141	763,507			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000	2,137	14,137			9
10	Nursing and Medical Records	1,195,479	93,353	6,981	1,295,813		1,295,813		1,295,813			10
10a	Therapy		224,372	423,088	647,460	(238,937)	408,523	107,394	515,917			10a
11	Activities	35,377	2,131		37,508		37,508	3	37,511			11
12	Social Services	29,408		5,248	34,656		34,656		34,656			12
13	CNA Training							965	965			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,260,264	319,856	447,317	2,027,437	(238,937)	1,788,500	110,499	1,898,999			16
	C. General Administration											
17	Administrative	74,757			74,757		74,757	61,799	136,556			17
18	Directors Fees											18
19	Professional Services			264,441	264,441		264,441	(237,923)	26,518			19
20	Dues, Fees, Subscriptions & Promotions			65,739	65,739	(39,968)	25,771	(3,883)	21,888			20
21	Clerical & General Office Expenses	134,364	31,801	6,758	172,923		172,923	126,501	299,424			21
22	Employee Benefits & Payroll Taxes			315,620	315,620		315,620	23,212	338,832			22
23	Inservice Training & Education			2,575	2,575		2,575	(576)	1,999			23
24	Travel and Seminar			979	979		979	1,020	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			48,660	48,660		48,660	8,303	56,963			26
27	Other (specify):*			12,000	12,000		12,000	(12,000)				27
28	**TOTAL General Administration**	209,121	31,801	716,772	957,694	(39,968)	917,726	(33,547)	884,179			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,826,446	610,677	1,299,374	3,736,497	(278,905)	3,457,592	89,093	3,546,685			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 COTILLION RIDGE NURSING CENTER #0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			103,238	103,238		103,238	6,944	110,182			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			46,810	46,810		46,810	(3,961)	42,849			32
33	Real Estate Taxes			21,117	21,117		21,117	40	21,157			33
34	Rent-Facility & Grounds			269,050	269,050		269,050	4,835	273,885			34
35	Rent-Equipment & Vehicles			9,066	9,066		9,066	887	9,953			35
36	Other (specify):*											36
37	TOTAL Ownership			449,281	449,281		449,281	8,745	458,026			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					238,937	238,937		238,937			39
40	Barber and Beauty Shops			16,759	16,759		16,759		16,759			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					39,968	39,968		39,968			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			16,759	16,759	278,905	295,664		295,664			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,826,446	610,677	1,765,414	4,202,537		4,202,537	97,838	4,300,375			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 COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(4,402)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)	(847)	23		16
17	Non-Care Related Fees	(473)	20		17
18	Fines and Penalties				18
19	Entertainment	(4,810)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,184)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)	27		24
25	Fund Raising, Advertising and Promotional	(10,893)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (37,609)		$	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)	135,447		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ 135,447		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ 97,838		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

COTILLION RIDGE NURSING CENTER

ID# 0045138

Report Period Beginning: 1-01-10

Ending: 12-31-10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5		0	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(473)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(4,184)	19	22
23				23
24		(12,000)	27	24
25		(10,893)	20	25
26				26
27				27
28				28
29		0	33	29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(27,550)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

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

	Operating Expenses A. General Services	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)	
1	Dietary	0	0	2,909	0	0	0	0	0	0	0	0	2,909	1
2	Food Purchase	0	0	(687)	0	0	0	0	0	0	0	0	(687)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,257	0	0	0	0	0	0	0	0	1,257	5
6	Maintenance	0	0	8,662	0	0	0	0	0	0	0	0	8,662	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	12,141	0	0	0	0	0	0	0	0	12,141	8
	B. Health Care and Programs													
9	Medical Director	0	0	2,137	0	0	0	0	0	0	0	0	2,137	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	107,394	0	0	0	0	0	0	0	0	0	107,394	10a
11	Activities	0	0	3	0	0	0	0	0	0	0	0	3	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	965	0	0	0	0	0	0	0	0	965	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	107,394	3,105	0	0	0	0	0	0	0	0	110,499	16
	C. General Administration													
17	Administrative	0	0	61,799	0	0	0	0	0	0	0	0	61,799	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,184)	(246,357)	12,618	0	0	0	0	0	0	0	0	(237,923)	19
20	Fees, Subscriptions & Promotions	(11,366)	0	7,483	0	0	0	0	0	0	0	0	(3,883)	20
21	Clerical & General Office Expenses	0	0	126,501	0	0	0	0	0	0	0	0	126,501	21
22	Employee Benefits & Payroll Taxes	0	0	23,212	0	0	0	0	0	0	0	0	23,212	22
23	Inservice Training & Education	(847)	0	271	0	0	0	0	0	0	0	0	(576)	23
24	Travel and Seminar	(4,810)	0	5,830	0	0	0	0	0	0	0	0	1,020	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	8,303	0	0	0	0	0	0	0	0	8,303	26
27	Other (specify):*	(12,000)	0	0	0	0	0	0	0	0	0	0	(12,000)	27
28	**TOTAL General Administration**	(33,207)	(246,357)	246,017	0	0	0	0	0	0	0	0	(33,547)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(33,207)	(138,963)	261,263	0	0	0	0	0	0	0	0	89,093	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 **Report Period Beginning:** 1-01-10 **Ending:** 12-31-10

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	0	0	6,944	0	0	0	0	0	0	0	6,944	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,402)	0	0	441	0	0	0	0	0	0	0	(3,961)	32
33	Real Estate Taxes	0	0	0	40	0	0	0	0	0	0	0	40	33
34	Rent-Facility & Grounds	0	0	0	4,835	0	0	0	0	0	0	0	4,835	34
35	Rent-Equipment & Vehicles	0	0	0	887	0	0	0	0	0	0	0	887	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(4,402)	0	0	13,147	0	0	0	0	0	0	0	8,745	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(37,609)	(138,963)	261,263	13,147	0	0	0	0	0	0	0	97,838	45

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Heritage Enterprises, Inc.	100	See Attached				

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			$			$	$	1
2	V	10a	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	107,394	107,394	2
3	V								3
4	V	19	Adjustment for Related Organization	246,357	Heritage Operations Group, LLC	0.00%		(246,357)	4
5	V								5
6	V	34	Adjustment for Related Organization		Heritage Manor Real Estate, LLC	0.00%			6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				10
11	V								11
12	V								12
13	V								13
14	Total			$ 246,357			$ 107,394	$ * (138,963)	14

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

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

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 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	1	Dietary	$	Heritage Enterprises, Inc.		$	$ 2,909	15
16	V	2	Food Purchase					(687)	16
17	V	3	Housekeeping					0	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,257	19
20	V	6	Maintenance					8,662	20
21	V	7	Other					0	21
22	V	9	Medical Director					2,137	22
23	V	10	Nursing & Medical Records					0	23
24	V	11	Activities					3	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					965	26
27	V	14	Program Transportation					0	27
28	V	15	Other					0	28
29	V	17	Administrative					61,799	29
30	V	18	Directors Fees					0	30
31	V	19	Professional Services					12,618	31
32	V	20	Fees, Subscription, Promotions					7,483	32
33	V	21	Clerical & General Office Expenses					126,501	33
34	V	22	Employee Benefits & Payroll Taxes					23,212	34
35	V	23	Inservice Training & Education					271	35
36	V	24	Travel and Seminar					5,830	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					8,303	38
39	Total			$			$ 0	$ * 261,263	39

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

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

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 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 Enterprises, Inc.		$	$ 0	15
16	V	30	Depreciation					6,944	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					441	18
19	V	33	Real Estate Taxes					40	19
20	V	34	Rent-Facility & Grounds					4,835	20
21	V	35	Rent-Equipment & Vehicles					887	21
22	V	36	Other					0	22
23	V	38	Medically Nec Transportation					0	23
24	V	39	Ancillary Service Centers					0	24
25	V	40	Barber and Beauty Shops					0	25
26	V	41	Coffee and Gift Shops					0	26
27	V	42	Other					0	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ * 13,147	39

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

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

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 Hours	6 Percent	7 Compensation Included in Costs for this Reporting Period** Description	7 Amount	8 Schedule V. Line & Column Reference	
1	Cheryl Lowney	Executive Vice Presi	Management	20.00					$ 0	18/7	1
2	Steve Wannemacher	President	Management	20.00							2
3	Connie Hoselton	Sr Vice President	Management	20.00							3
4	Craig Ater	Executive Vice Presi	Management	20.00							4
5	Joseph Warner Marital Trust			20.00							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 COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

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	1	Dietary	Beds	2,634	25	$ 104,969	$ 104,969	73	$ 2,909	1
2	2	Food Purchase	Beds	2,634	25	(24,794)	0	73	(687)	2
3	3	Housekeeping	Beds	2,634	25	0	0	73	0	3
4	4	Laundry	Beds	2,634	25	0	0	73	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	45,364	0	73	1,257	5
6	6	Maintenance	Beds	2,634	25	312,555	75,007	73	8,662	6
7	7	Other	Beds	2,634	25	0	0	73	0	7
8	9	Medical Director	Beds	2,634	25	77,111	0	73	2,137	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	77,111	73	0	9
10	11	Activities	Beds	2,634	25	95	0	73	3	10
11	12	Social Service	Beds	2,634	25	0	0	73	0	11
12	13	Nurse Aide Training	Beds	2,634	25	34,804	0	73	965	12
13	14	Program Transportation	Beds	2,634	25	0	0	73	0	13
14	15	Other	Beds	2,634	25	0	0	73	0	14
15	17	Administrative	Beds	2,634	25	2,229,831	2,229,831	73	61,799	15
16	18	Directors Fees	Beds	2,634	25	0	0	73	0	16
17	19	Professional Services	Beds	2,634	25	455,276	0	73	12,618	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	269,994	0	73	7,483	18
19	21	Clerical & General Office Expens	Beds	2,634	25	4,564,447	4,163,572	73	126,501	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	837,533	0	73	23,212	20
21	23	Inservice Training & Education	Beds	2,634	25	9,793	0	73	271	21
22	24	Travel and Seminar	Beds	2,634	25	210,373	0	73	5,830	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	73	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	299,608	0	73	8,303	24
25	TOTALS					$ 9,426,959	$ 6,650,490		$ 261,263	25

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

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

	1 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	2,634	25	$	$	73	$	1
2	30	Depreciation	Beds	2,634	25	250,538		73	6,944	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	25			73		3
4	32	Interest	Beds	2,634	25	15,900		73	441	4
5	33	Real Estate Taxes	Beds	2,634	25	1,448		73	40	5
6	34	Rent-Facility & Grounds	Beds	2,634	25	174,472		73	4,835	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	25	31,994		73	887	7
8	36	Other	Beds	2,634	25			73		8
9	38	Medically Nec Transportation	Beds	2,634	25			73		9
10	39	Ancillary Service Centers	Beds	2,634	25			73		10
11	40	Barber and Beauty Shops	Beds	2,634	25			73		11
12	41	Coffee and Gift Shops	Beds	2,634	25			73		12
13	42	Other	Beds	2,634	25			73		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					$ 474,352	$		$ 13,147	25

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Morton Community Bank		xx	Mortgage			$	$ 2,612,356	3/2011	variable	$ 46,032	1
2	Morton Community Bank		xx	Loan Fees							778	2
3												3
4												4
5												5
	Working Capital											
6	Morton Community Bank		xx	Accounts Receivable								6
7												7
8												8
9	TOTAL Facility Related						$	$ 2,612,356			$ 46,810	9
	B. Non-Facility Related*											
10	Interest Income										(4,402)	10
11	Allocated Corporate										441	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,961)	14
15	TOTALS (line 9+line14)						$	$ 2,612,356			$ 42,849	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	19,413	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.)	$	19,771	2
3. Under or (over) accrual (line 2 minus line 1).	$	358	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	20,759	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.	$	21,117	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	20,243	8
2006	17,871	9
2007	6,778	10
2008	24,295	11
2009	21,117	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME COTILLION RIDGE NURSING CENTER COUNTY Crawford

FACILITY IDPH LICENSE NUMBER 0045138

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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05427033042000	nursing home	$ 19,515.00	$ 19,515.00
2.	05427033041000		$ 256.00	$ 256.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 19,771.00	$ 19,771.00

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 _____ 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,195 B. General Construction Type: Exterior brick Frame wood Number of Stories 1

C. Does the Operating Entity? [x] (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? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [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				$ 26,000	1
2					2
3	TOTALS			$ 26,000	3

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	73		2010		$ 1,525,000	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Acquisition of Building Improvements from prior Operator			2001	154,177						9
10											10
11	Dinning Room/Day Room Addition---Outside Contractor			2001	164,291						11
12	Dinning Room/Day Room Addition---Design			2001	50,288						12
13	Dinning Room/Day Room Addition---Wallcoverings			2001	9,670						13
14											14
15	Dinning Room/Day Room Addition---Outside Contractor			2002	66,633						15
16	Dinning Room/Day Room Addition---Design			2002	4,665						16
17	Heating Duct Replacement			2002	12,146						17
18											18
19	Dinning Room/Day Room Addition---Paid by ProCare			2002	200,750						19
20	directly to General Contractor										20
21											21
22	Heat Pump			2003	12,720						22
23	Compressor			2003	1,333						23
24	A/C Unit			2003	2,569						24
25	Water Heater			2003	7,262						25
26	Sprinkler Head Replacements			2003	3,993						26
27	Asphalt Sealing			2003	1,260						27
28	idph			2003	8,618						28
29											29
30	Rewire Resident Rooms			2004	3,250						30
31											31
32											32
33	C/O Allocation							6,944	6,944		33
34	Book Depreciation					78,128		78,128			34
35											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 COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Parking Lot Sealer	2005	$ 1,260	$		$	$	$	37
38	Doors	2005	660						38
39	A/C compressor	2005	983						39
40	Sidewalk	2005	7,898						40
41	Ansul System	2005	1,990						41
42									42
43	Furnace	2006	4,850						43
44	Roof	2006	7,230						44
45	A/C compressor	2006	1,354						45
46	Water line	2006	1,119						46
47									47
48	A/C	2007	6,406						48
49	Parking Lot	2007	36,176						49
50									50
51	CC TV system	2008	3,397						51
52	Parking Lot	2008	15,919						52
53	Hallway Painting	2008	5,325						53
54	Landscaping	2008	9,896						54
55	Exit Doors	2008	4,138						55
56									56
57									57
58	Furnace	2009	7,443						58
59	Dumpster Pad	2009	3,400						59
60	Parking Lot	2009	2,619						60
61	Door Closers	2009	4,465						61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,355,153	$ 78,128		$ 85,072	$ 6,944	$	70

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

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 2,355,153	$ 78,128		$ 85,072	$ 6,944	$	1
2	The following items relate to the rehab of 2 wings and central								2
3	common area spaces performed by DS Renovations, LLC								3
4	General Conditions & Demolition	2009	73,230						4
5	Carpentry & Millwork	2009	45,270						5
6	Acoustical Ceiling & Flooring	2009	49,176						6
7	Painting	2009	36,800						7
8	Plumbing	2009	10,600						8
9	Electrical	2009	18,430						9
10	Design and layout	2009	13,837						10
11	Project Materials	2009	99,339						11
12	Interior Doors and toilets & related hardware	2009	67,621						12
13	Flooring Central Core	2009	23,320						13
14									14
15	Service sink	2010	5,225						15
16	AHU replacement	2010	4,934						16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,802,935	$ 78,128		$ 85,072	$ 6,944	$	34

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

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 2,802,935	$ 78,128		$ 85,072	$ 6,944	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,802,935	$ 78,128		$ 85,072	$ 6,944	$	34

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

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 2,802,935	$ 78,128		$ 85,072	$ 6,944	$	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
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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)		$ 2,802,935	$ 78,128		$ 85,072	$ 6,944	$	34

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

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 671,141	$ 25,110	$ 25,110	$		$	71
72	Current Year Purchases	36,775						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 707,916	$ 25,110	$ 25,110	$		$	75

D. Vehicle Depreciation (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		2008 Chevy Van		$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	3,536,851	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	103,238	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	110,182	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	6,944	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 COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ProCare Inc
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. [x] 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:		73	2000	$ 269,050	10		3
4	Additions							4
5								5
6								6
7	TOTAL		73		$ 269,050 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [x] YES [ ] NO Terms: Purchased 11/1/10 *

10. Effective dates of current rental agreement:
Beginning 1/1/10
Ending 10/31/10

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2011	$ 269,050
13.	/2012	$
14.	/2013	$

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: $ 9,066 Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* 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.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

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.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 139,053	$		$ 139,053	1
2	Licensed Speech and Language Development Therapist		hrs			70,383			70,383	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			196,978	2,109		199,087	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				222,263		222,263	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					16,674			16,674	13
14	TOTAL			$		$ 423,088	$ 224,372		$ 647,460	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 COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12-31-10 (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	$ 665,338	$	1
2	Cash-Patient Deposits	594		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	153,003		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,926		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 846,861	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	26,000		13
14	Buildings, at Historical Cost	2,605,950		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	657,060		16
17	Accumulated Depreciation (book methods)	(871,058)		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):	160,885		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,578,837	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,425,698	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 127,504	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	594		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	20,759		32
33	Accrued Interest Payable	1,088		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 149,945	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,612,356		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)**	$ 2,612,356	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,762,301	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 663,397	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,425,698	$	48

***(See instructions.)**

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 651,167	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 651,167	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	12,230	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)**	$ 12,230	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)**	$ 663,397	24 *

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

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,952,320	1
2	Discounts and Allowances for all Levels	(1,508,769)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,443,551	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,359,644	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,359,644	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	18,258	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	384,847	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	4,950	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 408,055	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,402	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,402	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other	(885)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (885)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,214,767	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	751,366	31
32	Health Care	2,027,437	32
33	General Administration	957,694	33
	B. Capital Expense		
34	Ownership	449,281	34
	C. Ancillary Expense		
35	Special Cost Centers	16,759	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)***	$ 4,202,537	40
41	**Income before Income Taxes (line 30 minus line 40)****	12,230	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 12,230	43

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

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

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

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

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,712	2,007	$ 50,840	$ 25.33	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	9,296	9,356	273,725	29.26	3
4	Licensed Practical Nurses	9,704	9,952	179,102	18.00	4
5	CNAs & Orderlies	55,352	58,845	622,574	10.58	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,035	4,358	69,238	15.89	8
9	Activity Director					9
10	Activity Assistants	3,990	4,273	35,377	8.28	10
11	Social Service Workers	1,830	2,116	29,408	13.90	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,656	18,880	170,503	9.03	15
16	Dishwashers					16
17	Maintenance Workers	4,009	4,229	46,704	11.04	17
18	Housekeepers	9,528	9,864	91,480	9.27	18
19	Laundry	2,654	2,788	48,374	17.35	19
20	Administrator	1,900	2,080	74,757	35.94	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,829	8,666	134,364	15.50	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)	129,495	137,414	$ 1,826,446 *	$ 13.29	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		12,000		36
37	Medical Records Consultant		885		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,197		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		5,248		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 22,330		49

C. CONTRACT NURSES

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

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Roxanne Summers			$ 74,757
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 74,757

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	Mgt Fee	$ 246,357
McQuellen Consulting	R/E appeals	0
Sulaski & Webb	audit	13,900
Legal adj to Zero		4,184
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 264,441

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 15,282
Unemployment Compensation Insurance	21,971
FICA Taxes	139,723
Employee Health Insurance	115,683
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
	0
Other Benefits	22,961
Central Office Allocation	23,212
TOTAL (agree to Schedule V, line 22, col.8)	$ 338,832

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	$ 0
Advertising: Employee Recruitment	4,422
Health Care Worker Background Check	
(Indicate # of checks performed)	1,568
Patient Background Checks	
	3,317
Dues & Subscriptions	4,548
License & Fees	4,340
Central Office Allocation	7,483
Less: Public Relations Expense	(3,317)
Non-allowable advertising	(473)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,888

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
	44
Seminar Expense	935
Central Office	1,020
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

**See instructions.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 1-01-10 Ending: 12-31-10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Illinois Health Care Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **yes** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7yrs**

(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 **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **x** NO 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. $ **39,968**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **790**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **sulaski & webb**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.