

		FOR BHF USE				

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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 ROBINSON 62454
 Number City Zip Code

County: Crawford

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

HFS ID Number: 371402726

Date of Initial License for Current Owners: 2000

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/07 to 12/31/07 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) _____	<u>04/15/08</u>
	(Type or Print Name) <u>Craig Ater</u>	(Date)
Paid Preparer	(Title) <u>Sr. VP & CFO</u>	
	(Signed) _____	(Date)
Paid Preparer	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) <u>()</u>	Fax # <u>()</u>
	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: 01/01/07 Ending: 12/31/07

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	<u>73</u>	Skilled (SNF)	<u>73</u>	<u>26,645</u>	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	<u>73</u>	TOTALS	<u>73</u>	<u>26,645</u>	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	<u>12,540</u>	<u>8,542</u>	<u>4,053</u>	<u>25,135</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,540</u>	<u>8,542</u>	<u>4,053</u>	<u>25,135</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.33%

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)
_____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 2000

J. Was the facility purchased or leased after January 1, 1978?

YES Date 2000 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided 4,053Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	140,547	6,297		146,844		146,844	3,960	150,804		1
2	Food Purchase		119,712		119,712		119,712	16	119,728		2
3	Housekeeping	60,214	14,979		75,193		75,193		75,193		3
4	Laundry	33,772	8,159		41,931		41,931		41,931		4
5	Heat and Other Utilities			66,127	66,127		66,127	1,129	67,256		5
6	Maintenance	50,304	28,530	38,534	117,368		117,368	8,950	126,318		6
7	Other (specify):*										7
8	TOTAL General Services	284,837	177,677	104,661	567,175		567,175	14,055	581,230		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000	1,418	13,418		9
10	Nursing and Medical Records	1,027,321	85,967	4,203	1,117,491		1,117,491		1,117,491		10
10a	Therapy		211,481	425,232	636,713	(232,232)	404,481	98,239	502,720		10a
11	Activities	33,693	2,490		36,183		36,183	1,030	37,213		11
12	Social Services	31,948	1,493	4,941	38,382		38,382		38,382		12
13	CNA Training							1,312	1,312		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,092,962	301,431	446,376	1,840,769	(232,232)	1,608,537	101,999	1,710,536		16
	C. General Administration										
17	Administrative	57,115			57,115		57,115	46,968	104,083		17
18	Directors Fees							4,179	4,179		18
19	Professional Services			253,733	253,733		253,733	(237,659)	16,074		19
20	Dues, Fees, Subscriptions & Promotions			61,712	61,712	(39,968)	21,744	(7,640)	14,104		20
21	Clerical & General Office Expenses	124,628	20,289	7,772	152,689		152,689	103,113	255,802		21
22	Employee Benefits & Payroll Taxes			322,195	322,195		322,195	28,239	350,434		22
23	Inservice Training & Education			1,220	1,220		1,220	292	1,512		23
24	Travel and Seminar			2,857	2,857		2,857	(858)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			51,002	51,002		51,002	4,163	55,165		26
27	Other (specify):*			10,479	10,479		10,479	(10,200)	279		27
28	TOTAL General Administration	181,743	20,289	710,970	913,002	(39,968)	873,034	(69,403)	803,631		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,559,542	499,397	1,262,007	3,320,946	(272,200)	3,048,746	46,651	3,095,397		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: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			94,472	94,472		94,472	7,225	101,697			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,877	16,877		16,877	570	17,447			32
33	Real Estate Taxes			17,871	17,871		17,871		17,871			33
34	Rent-Facility & Grounds			301,693	301,693		301,693	4,412	306,105			34
35	Rent-Equipment & Vehicles			5,464	5,464		5,464	1,201	6,665			35
36	Other (specify):*											36
37	TOTAL Ownership			436,377	436,377		436,377	13,408	449,785			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					232,232	232,232		232,232			39
40	Barber and Beauty Shops			16,004	16,004		16,004		16,004			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			16,004	16,004	272,200	288,204		288,204			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,559,542	499,397	1,714,388	3,773,327		3,773,327	60,059	3,833,386			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: 01/01/07

Ending: 12/31/07

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		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	(4,312)	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)		24		16
17	Non-Care Related Fees	(494)	20		17
18	Fines and Penalties				18
19	Entertainment	(7,646)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(875)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,200)	27		24
25	Fund Raising, Advertising and Promotional	(11,594)	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		33		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (35,121)		\$	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)	95,180		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 95,180		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 60,059		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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

STATE OF ILLINOIS
 COTILLION RIDGE NURSING CENTER

ID# 0045138
 Report Period Beginning: 01/01/07
 Ending: 12/31/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$		1
2			2
3			3
4			4
5		0	35
6		0	34
7			7
8			8
9		0	30
10			32
11			11
12			12
13		0	2
14			32
15		0	33
16			24
17		(494)	20
18			18
19			24
20		0	27
21			21
22		(875)	19
23			23
24		(10,200)	27
25		(11,594)	20
26			26
27			27
28			28
29		0	33
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	(23,163)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COTILLION RIDGE NURSING CENTER

0045138

Report Period Beginning:

01/01/07

Ending:

12/31/07

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)	
	A. General Services													
1	Dietary	0	0	3,960	0	0	0	0	0	0	0	0	3,960	1
2	Food Purchase	0	0	16	0	0	0	0	0	0	0	0	16	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	1,129	0	0	0	0	0	0	0	0	1,129	5
6	Maintenance	0	0	8,950	0	0	0	0	0	0	0	0	8,950	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	14,055	0	0	0	0	0	0	0	0	14,055	8
	B. Health Care and Programs													
9	Medical Director	0	0	1,418	0	0	0	0	0	0	0	0	1,418	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	98,239	0	0	0	0	0	0	0	0	0	98,239	10a
11	Activities	0	0	1,030	0	0	0	0	0	0	0	0	1,030	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,312	0	0	0	0	0	0	0	0	1,312	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	98,239	3,760	0	0	0	0	0	0	0	0	101,999	16
	C. General Administration													
17	Administrative	0	0	46,968	0	0	0	0	0	0	0	0	46,968	17
18	Directors Fees	0	0	4,179	0	0	0	0	0	0	0	0	4,179	18
19	Professional Services	(875)	(242,658)	5,874	0	0	0	0	0	0	0	0	(237,659)	19
20	Fees, Subscriptions & Promotions	(12,088)	0	4,448	0	0	0	0	0	0	0	0	(7,640)	20
21	Clerical & General Office Expenses	0	0	103,113	0	0	0	0	0	0	0	0	103,113	21
22	Employee Benefits & Payroll Taxes	0	0	28,239	0	0	0	0	0	0	0	0	28,239	22
23	Inservice Training & Education	0	0	292	0	0	0	0	0	0	0	0	292	23
24	Travel and Seminar	(7,646)	0	6,788	0	0	0	0	0	0	0	0	(858)	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	4,163	0	0	0	0	0	0	0	0	4,163	26
27	Other (specify):*	(10,200)	0	0	0	0	0	0	0	0	0	0	(10,200)	27
28	TOTAL General Administration	(30,809)	(242,658)	204,064	0	0	0	0	0	0	0	0	(69,403)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(30,809)	(144,419)	221,879	0	0	0	0	0	0	0	0	46,651	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	7,225	0	0	0	0	0	0	0	7,225	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,312)	0	0	4,882	0	0	0	0	0	0	0	570	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	4,412	0	0	0	0	0	0	0	4,412	34
35	Rent-Equipment & Vehicles	0	0	0	1,201	0	0	0	0	0	0	0	1,201	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(4,312)	0	0	17,720	0	13,408	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)	(35,121)	(144,419)	221,879	17,720	0	60,059	45						

Facility Name & ID Number COTILLION RIDGE NURSING CENTER

0045138

Report Period Beginning:

01/01/07

Ending:

12/31/07

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
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. 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		\$			\$	\$
2	V	10a Adjustment for Related Organization					
3	V						
4	V	19 Adjustment for Related Organization	242,658	Heritage Enterprises, Inc.			(242,658)
5	V						
6	V	10a Adjustment for Related Organization		GreenTree Pharmacy		98,239	98,239
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 242,658			\$ 98,239	\$ * (144,419)

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

Facility Name & ID Number COTILLION RIDGE NURSING CENTER# 0045138Report Period Beginning: 01/01/07Ending: 12/31/07

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 Enterprises, Inc.	100.00%	\$	3,960	15
16	V	2 Food Purchase					16	16
17	V	3 Housekeeping					0	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					1,129	19
20	V	6 Maintenance					8,950	20
21	V	7 Other					0	21
22	V	9 Medical Director					1,418	22
23	V	10 Nursing & Medical Records					0	23
24	V	11 Activities					1,030	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					1,312	26
27	V	14 Program Transportation					0	27
28	V	15 Other					0	28
29	V	17 Administrative					46,968	29
30	V	18 Directors Fees					4,179	30
31	V	19 Professional Services					5,874	31
32	V	20 Fees, Subscription, Promotions					4,448	32
33	V	21 Clerical & General Office Expenses					103,113	33
34	V	22 Employee Benefits & Payroll Taxes					28,239	34
35	V	23 Inservice Training & Education					292	35
36	V	24 Travel and Seminar					6,788	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					4,163	38
39	Total		\$			\$	0	\$ * 221,879 39

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

Facility Name & ID Number COTILLION RIDGE NURSING CENTER# 0045138Report Period Beginning: 01/01/07Ending: 12/31/07

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		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
		Item	4 Amount	Name of Related Organization						
15	V	27	Other	\$		100.00%	\$	0	15	
16	V	30	Depreciation					7,225	16	
17	V	31	Amortization of Pre-Op & Org						17	
18	V	32	Interest					4,882	18	
19	V	33	Real Estate Taxes					0	19	
20	V	34	Rent-Facility & Grounds					4,412	20	
21	V	35	Rent-Equipment & Vehicles					1,201	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	\$ * 17,720	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: 01/01/07 Ending: 12/31/07

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	Cheryl Lowney	Executive Vice Presi	Management	20.00				Brd Fees	\$ 4,179	line 18	1
2	Steve Wannemacher	President	Management	20.00							2
3	Connie Hoselton	Sr Vice President	Management	20.00							3
4	Craig Ater	Sr Vice President	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	\$ 4,179		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: 01/01/07

Ending: 12/31/07

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	2,624	25	\$ 142,342	\$ 142,057	73	\$ 3,960	1
2	2	Food Purchase	Beds	2,624	25	577	0	73	16	2
3	3	Housekeeping	Beds	2,624	25	0	0	73	0	3
4	4	Laundry	Beds	2,624	25	0	0	73	0	4
5	5	Heat & Other Utilities	Beds	2,624	25	40,565	0	73	1,129	5
6	6	Maintenance	Beds	2,624	25	321,709	65,509	73	8,950	6
7	7	Other	Beds	2,624	25	0	0	73	0	7
8	9	Medical Director	Beds	2,624	25	50,960	0	73	1,418	8
9	10	Nursing & Medical Records	Beds	2,624	25	0	56,488	73	0	9
10	11	Activities	Beds	2,624	25	37,038	36,931	73	1,030	10
11	12	Social Service	Beds	2,624	25	0	0	73	0	11
12	13	Nurse Aide Training	Beds	2,624	25	47,168	47,168	73	1,312	12
13	14	Program Transportation	Beds	2,624	25	0	0	73	0	13
14	15	Other	Beds	2,624	25	0	0	73	0	14
15	17	Administrative	Beds	2,624	25	1,688,288	1,688,288	73	46,968	15
16	18	Directors Fees	Beds	2,624	25	150,218	0	73	4,179	16
17	19	Professional Services	Beds	2,624	25	211,148	0	73	5,874	17
18	20	Fees, Subscription, Promotions	Beds	2,624	25	159,872	0	73	4,448	18
19	21	Clerical & General Office Expense	Beds	2,624	25	3,706,408	3,356,042	73	103,113	19
20	22	Employee Benefits & Payroll Tax	Beds	2,624	25	1,015,049	0	73	28,239	20
21	23	Inservice Training & Education	Beds	2,624	25	10,511	0	73	292	21
22	24	Travel and Seminar	Beds	2,624	25	243,988	0	73	6,788	22
23	25	Other Admin. Staff Transportatio	Beds	2,624	25	0	0	73	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,624	25	149,629	0	73	4,163	24
25	TOTALS					\$ 7,975,470	\$ 5,392,483		\$ 221,879	25

Facility Name & ID Number COTILLION RIDGE NURSING CENTER

0045138

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 _____
 Street Address _____
 City / State / Zip Code _____
 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	27	Other	Beds	2,624	25	\$	73	\$	1
2	30	Depreciation	Beds	2,624	25	259,703	73	7,225	2
3	31	Amortization of Pre-Op & Org	Beds	2,624	25		73		3
4	32	Interest	Beds	2,624	25	175,477	73	4,882	4
5	33	Real Estate Taxes	Beds	2,624	25		73		5
6	34	Rent-Facility & Grounds	Beds	2,624	25	158,587	73	4,412	6
7	35	Rent-Equipment & Vehicles	Beds	2,624	25	43,166	73	1,201	7
8	36	Other	Beds	2,624	25		73		8
9	38	Medically Nec Transportation	Beds	2,624	25		73		9
10	39	Ancillary Service Centers	Beds	2,624	25		73		10
11	40	Barber and Beauty Shops	Beds	2,624	25		73		11
12	41	Coffee and Gift Shops	Beds	2,624	25		73		12
13	42	Other	Beds	2,624	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					\$ 636,933	\$	\$ 17,720	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Alpha Bank		xx	Mortgage			\$	152,104		\$	16,877	1								
2	Alpha Bank		xx	Mortgage								2								
3												3								
4												4								
5												5								
Working Capital																				
6	Alpha Bank		xx	Working Capital								6								
7	Alpha Bank		xx									7								
8												8								
9	TOTAL Facility Related						\$	152,104		\$	16,877	9								
B. Non-Facility Related*																				
10	Interest Income										(4,312)	10								
11	Allocated Corporate										4,882	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$			\$	570	14								
15	TOTALS (line 9+line14)						\$	152,104		\$	17,447	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.)

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																				
1. Real Estate Tax accrual used on 2006 report.		\$ 20,758	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.)		\$ 18,843	2																																	
3. Under or (over) accrual (line 2 minus line 1).		\$ (1,915)	3																																	
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 19,786	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.		\$ 17,871	7																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2002</td><td>17,273</td><td>8</td></tr> <tr><td>2003</td><td>17,140</td><td>9</td></tr> <tr><td>2004</td><td>17,374</td><td>10</td></tr> <tr><td>2005</td><td>20,243</td><td>11</td></tr> <tr><td>2006</td><td>17,871</td><td>12</td></tr> </table>	2002	17,273	8	2003	17,140	9	2004	17,374	10	2005	20,243	11	2006	17,871	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2006</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>	FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2006	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
2002	17,273	8																																		
2003	17,140	9																																		
2004	17,374	10																																		
2005	20,243	11																																		
2006	17,871	12																																		
FOR BHF USE ONLY																																				
13	FROM R. E. TAX STATEMENT FOR 2006	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 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 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>05-4-27-033-041-000</u>	<u>nursing home</u>	\$ <u>243.00</u>	\$ <u>243.00</u>
2. <u>05-4-033-042-000</u>	<u></u>	\$ <u>18,600.00</u>	\$ <u>18,600.00</u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
	TOTALS	\$ <u>18,843.00</u>	\$ <u>18,843.00</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? YES NO

If YES, attach an explanation & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

01/01/07 Ending:

12/31/07

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? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

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

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>1,000</u>	1
2					2
3	TOTALS			\$ 1,000	3

Facility Name & ID Number **COTILLION RIDGE NURSING CENTER**

0045138

Report Period Beginning:

01/01/07

Ending:

12/31/07

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				\$	\$		\$	\$	\$	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											33
34		C/O Allocation						7,225	7,225		34
35		Book Depreciation				36,714		36,714		205,968	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	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									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66	rooms including hallways and common areas								66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 773,551	\$ 36,714		\$ 43,939	\$ 7,225	\$ 205,968	70

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

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 773,551	\$ 36,714		\$ 43,939	\$ 7,225	\$ 205,968	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)	\$ 773,551	\$ 36,714		\$ 43,939	\$ 7,225	\$ 205,968	34

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

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 773,551	\$ 36,714		\$ 43,939	\$ 7,225	\$ 205,968	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)	\$ 773,551	\$ 36,714		\$ 43,939	\$ 7,225	\$ 205,968	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: 01/01/07 Ending: 12/31/07

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	\$ 530,986	\$ 57,758	\$ 57,758	\$		\$ 451,918	71
72	Current Year Purchases	4,846						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 535,832	\$ 57,758	\$ 57,758	\$		\$ 451,918	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				\$	\$	\$	\$		\$	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)	\$ 1,310,383	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 94,472	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 101,697	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,225	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 657,886	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: Pro Care 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.

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:				\$ <u>301,693</u>	<u>10</u>		3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>301,693</u>			7

10. Effective dates of current rental agreement:

Beginning 2000

Ending 2010

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

Fiscal Year Ending Annual Rent

12.	<u>/2008</u>	\$ <u>301,693</u>
13.	<u>/2009</u>	\$ <u>301,693</u>
14.	<u>/2010</u>	\$ <u>301,693</u>

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: YES NO Terms: 1550000 *

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: \$ 6,665 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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 134,185	\$		\$ 134,185	1
2	Licensed Speech and Language Development Therapist		hrs			48,856			48,856	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			220,049	1,391		221,440	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				210,090		210,090	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					22,142			22,142	13
14	TOTAL			\$		\$ 425,232	\$ 211,481		\$ 636,713	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: **01/01/07**

Ending:

12/31/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/07**

(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	\$ 218,960	\$	1
2	Cash-Patient Deposits	1,136		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	398,090		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,541		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)	\$ 642,727	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,000		13
14	Buildings, at Historical Cost	572,821		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	486,581		16
17	Accumulated Depreciation (book methods)	(657,886)		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):	146,413		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 548,929	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,191,656	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 98,750	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,136		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)	19,786		32
33	Accrued Interest Payable	916		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)	\$ 120,588	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	152,104		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)	\$ 152,104	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 272,692	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 918,964	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,191,656	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 754,142	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 754,142	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	\$ 264,822	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	\$ (100,000)	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)	\$ 164,822	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)	\$ 918,964	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER

0045138

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,887,453	1
2	Discounts and Allowances for all Levels	(1,864,899)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,022,554	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,624,803	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,624,803	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	16,695	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	369,785	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 386,480	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,312	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,312	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,038,149	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	567,175	31
32	Health Care	1,840,769	32
33	General Administration	913,002	33
B. Capital Expense			
34	Ownership	436,377	34
C. Ancillary Expense			
35	Special Cost Centers	16,004	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)*	\$ 3,773,327	40
41	Income before Income Taxes (line 30 minus line 40)**	264,822	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 264,822	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:

01/01/07

Ending:

12/31/07

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	1,768	1,922	\$ 40,361	\$ 21.00	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	7,896	8,457	176,020	20.81	3
4	Licensed Practical Nurses	10,887	11,684	185,943	15.91	4
5	CNAs & Orderlies	51,214	55,503	554,558	9.99	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,017	4,335	70,439	16.25	8
9	Activity Director					9
10	Activity Assistants	3,192	3,688	33,693	9.14	10
11	Social Service Workers	2,207	2,431	31,948	13.14	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,310	16,444	140,547	8.55	15
16	Dishwashers					16
17	Maintenance Workers	3,701	4,330	50,304	11.62	17
18	Housekeepers	7,400	7,942	60,214	7.58	18
19	Laundry	2,695	2,879	33,772	11.73	19
20	Administrator	1,900	2,080	57,115	27.46	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,326	8,915	124,628	13.98	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)	120,513	130,610	\$ 1,559,542 *	\$ 11.94	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 0		35
36	Medical Director	12,000		36
37	Medical Records Consultant	1,180		37
38	Nurse Consultant			38
39	Pharmacist Consultant	2,190		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	4,941		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 20,311		49

C. CONTRACT NURSES

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

Facility Name & ID Number COTILLION RIDGE NURSING CENTER

0045138

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Healthcare 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? _____
- (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 _____ NO xx 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. \$ 2,645
- (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? _____ 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? _____
- g. Does the facility transport residents to and from day training? _____**
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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. Not available at this date
- (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.

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