

		FOR BHF USE					

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

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.

<p>I. IDPH License ID Number: <u>0045138</u></p> <p>Facility Name: <u>COTILLION RIDGE NURSING CENTER</u></p> <p>Address: <u>600 EAST ROBINWOOD DRIVE</u> <u>ROBINSON</u> <u>62454</u> Number City Zip Code</p> <p>County: <u>Crawford</u></p> <p>Telephone Number: <u>(618) 544-3192</u> Fax # <u>()</u></p> <p>HFS ID Number: <u>371402726</u></p> <p>Date of Initial License for Current Owners: <u>2000</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Craig Ater</u> Telephone Number: <u>(309) 823-7135</u> Email Address: _____</p>	<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 _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/08</u> to <u>12/31/08</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Craig L. Ater</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>Exec V.P. & CFO</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Craig L. Ater</u> <u>Exec V.P. & CFO</u></td> </tr> <tr> <td>(Firm Name & Address) <u>Heritage Operations Group, LLC.</u></td> </tr> <tr> <td>(Telephone) <u>()</u> Fax # <u>()</u></td> </tr> </table> <p align="center">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</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Craig L. Ater</u> (Date) _____		(Title) <u>Exec V.P. & CFO</u>	Paid Preparer	(Signed) _____ (Date) _____	(Print Name and Title) <u>Craig L. Ater</u> <u>Exec V.P. & CFO</u>	(Firm Name & Address) <u>Heritage Operations Group, LLC.</u>	(Telephone) <u>()</u> Fax # <u>()</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
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	(Telephone) <u>()</u> Fax # <u>()</u>																																		

Facility Name & ID Number COTILLION RIDGE NURSING CENTER# 0045138 Report Period Beginning: 01/01/08 Ending: 12/31/08

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>12,840</u>	<u>8,615</u>	<u>3,849</u>	<u>25,304</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>12,840</u>	<u>8,615</u>	<u>3,849</u>	<u>25,304</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.97%

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)

noneF. 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 3,849Medicare 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: 01/01/08 Ending: 12/31/08

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	153,766	13,288		167,054		167,054	4,018	171,072		1
2	Food Purchase		129,118		129,118		129,118		129,118		2
3	Housekeeping	74,398	11,713		86,111		86,111	15	86,126		3
4	Laundry	40,330	7,506		47,836		47,836		47,836		4
5	Heat and Other Utilities			89,783	89,783		89,783	1,414	91,197		5
6	Maintenance	52,678	33,206	43,737	129,621		129,621	10,063	139,684		6
7	Other (specify):*										7
8	TOTAL General Services	321,172	194,831	133,520	649,523		649,523	15,510	665,033		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000	1,641	13,641		9
10	Nursing and Medical Records	1,117,760	105,347	3,650	1,226,757		1,226,757		1,226,757		10
10a	Therapy		167,025	373,636	540,661	(180,673)	359,988	108,163	468,151		10a
11	Activities	36,429	2,412		38,841		38,841	1,056	39,897		11
12	Social Services	28,674	1,159	5,707	35,540		35,540		35,540		12
13	CNA Training							835	835		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,182,863	275,943	394,993	1,853,799	(180,673)	1,673,126	111,695	1,784,821		16
	C. General Administration										
17	Administrative	76,578			76,578		76,578	50,881	127,459		17
18	Directors Fees							5,420	5,420		18
19	Professional Services			263,337	263,337		263,337	(244,516)	18,821		19
20	Dues, Fees, Subscriptions & Promotions			64,408	64,408	(39,968)	24,440	(7,162)	17,278		20
21	Clerical & General Office Expenses	123,937	25,327	5,550	154,814		154,814	114,166	268,980		21
22	Employee Benefits & Payroll Taxes			332,120	332,120		332,120	23,332	355,452		22
23	Inservice Training & Education			1,999	1,999		1,999		1,999		23
24	Travel and Seminar			4,777	4,777		4,777	(2,778)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			50,302	50,302		50,302	8,112	58,414		26
27	Other (specify):*			10,200	10,200		10,200	(10,200)			27
28	TOTAL General Administration	200,515	25,327	732,693	958,535	(39,968)	918,567	(62,745)	855,822		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,704,550	496,101	1,261,206	3,461,857	(220,641)	3,241,216	64,460	3,305,676		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: 01/01/08 Ending: 12/31/08

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			49,349	49,349		49,349	7,800	57,149			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,528	3,528		3,528	1,166	4,694			32
33	Real Estate Taxes			6,778	6,778		6,778		6,778			33
34	Rent-Facility & Grounds			312,300	312,300		312,300	7,918	320,218			34
35	Rent-Equipment & Vehicles			7,012	7,012		7,012	1,350	8,362			35
36	Other (specify):*											36
37	TOTAL Ownership			378,967	378,967		378,967	18,234	397,201			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					180,673	180,673		180,673			39
40	Barber and Beauty Shops			15,234	15,234		15,234		15,234			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			15,234	15,234	220,641	235,875		235,875			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,704,550	496,101	1,655,407	3,856,058		3,856,058	82,694	3,938,752			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: 01/01/08

Ending: 12/31/08

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	(3,528)	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)	(498)	23		16
17	Non-Care Related Fees	(573)	20		17
18	Fines and Penalties				18
19	Entertainment	(10,083)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(630)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,200)	27		24
25	Fund Raising, Advertising and Promotional	(11,501)	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)	\$ (37,013)		\$	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)	119,707		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 119,707		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 82,694		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

STATE OF ILLINOIS
 COTILLION RIDGE NURSING CENTER

ID# 0045138
 Report Period Beginning: 01/01/08
 Ending: 12/31/08

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		(498)	23
17		(573)	20
18			18
19			24
20		0	27
21			21
22		(630)	19
23			23
24		(10,200)	27
25		(11,501)	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	(23,402)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COTILLION RIDGE NURSING CENTER

0045138

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	4,018	0	0	0	0	0	0	0	0	4,018	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	15	0	0	0	0	0	0	0	0	15	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,414	0	0	0	0	0	0	0	0	1,414	5
6	Maintenance	0	0	10,063	0	0	0	0	0	0	0	0	10,063	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	15,510	0	0	0	0	0	0	0	0	15,510	8
	B. Health Care and Programs													
9	Medical Director	0	0	1,641	0	0	0	0	0	0	0	0	1,641	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	108,163	0	0	0	0	0	0	0	0	0	108,163	10a
11	Activities	0	0	1,056	0	0	0	0	0	0	0	0	1,056	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	835	0	0	0	0	0	0	0	0	835	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	108,163	3,532	0	0	0	0	0	0	0	0	111,695	16
	C. General Administration													
17	Administrative	0	0	50,881	0	0	0	0	0	0	0	0	50,881	17
18	Directors Fees	0	0	5,420	0	0	0	0	0	0	0	0	5,420	18
19	Professional Services	(630)	(249,407)	5,521	0	0	0	0	0	0	0	0	(244,516)	19
20	Fees, Subscriptions & Promotions	(12,074)	0	4,912	0	0	0	0	0	0	0	0	(7,162)	20
21	Clerical & General Office Expenses	0	0	114,166	0	0	0	0	0	0	0	0	114,166	21
22	Employee Benefits & Payroll Taxes	0	0	23,332	0	0	0	0	0	0	0	0	23,332	22
23	Inservice Training & Education	(498)	0	498	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(10,083)	0	7,305	0	0	0	0	0	0	0	0	(2,778)	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	8,112	0	0	0	0	0	0	0	0	8,112	26
27	Other (specify):*	(10,200)	0	0	0	0	0	0	0	0	0	0	(10,200)	27
28	TOTAL General Administration	(33,485)	(249,407)	220,147	0	0	0	0	0	0	0	0	(62,745)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(33,485)	(141,244)	239,189	0	0	0	0	0	0	0	0	64,460	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	7,800	0	0	0	0	0	0	0	7,800	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,528)	0	0	4,694	0	0	0	0	0	0	0	1,166	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	7,918	0	0	0	0	0	0	0	7,918	34
35	Rent-Equipment & Vehicles	0	0	0	1,350	0	0	0	0	0	0	0	1,350	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,528)	0	0	21,762	0	18,234	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)	(37,013)	(141,244)	239,189	21,762	0	82,694	45						

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				108,163	108,163
3	V						
4	V	19 Adjustment for Related Organization	249,407	Heritage Operations Group, LLC	0.00%		(249,407)
5	V						
6	V	10a Adjustment for Related Organization		GreenTree Pharmacy	0.00%		
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 249,407			\$ 108,163	\$ * (141,244)

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

Facility Name & ID Number COTILLION RIDGE NURSING CENTER# 0045138Report Period Beginning: 01/01/08Ending: 12/31/08

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.	0.00%	\$ 4,018	\$ 4,018	15
16	V	2 Food Purchase				0		16
17	V	3 Housekeeping				15	15	17
18	V	4 Laundry				0		18
19	V	5 Heat & Other Utilities				1,414	1,414	19
20	V	6 Maintenance				10,063	10,063	20
21	V	7 Other				0		21
22	V	9 Medical Director				1,641	1,641	22
23	V	10 Nursing & Medical Records				0		23
24	V	11 Activities				1,056	1,056	24
25	V	12 Social Service				0		25
26	V	13 Nurse Aide Training				835	835	26
27	V	14 Program Transportation				0		27
28	V	15 Other				0		28
29	V	17 Administrative				50,881	50,881	29
30	V	18 Directors Fees				5,420	5,420	30
31	V	19 Professional Services				5,521	5,521	31
32	V	20 Fees, Subscription, Promotions				4,912	4,912	32
33	V	21 Clerical & General Office Expenses				114,166	114,166	33
34	V	22 Employee Benefits & Payroll Taxes				23,332	23,332	34
35	V	23 Inservice Training & Education				498	498	35
36	V	24 Travel and Seminar				7,305	7,305	36
37	V	25 Other Admin. Staff Transportation				0		37
38	V	26 Insurance-Prop.Liab.Malpract				8,112	8,112	38
39	Total		\$			\$ 239,189	\$ * 239,189	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27 Other	\$		0.00%	\$ 0	\$	15
16	V	30 Depreciation				7,800	7,800	16
17	V	31 Amortization of Pre-Op & Org				0		17
18	V	32 Interest				4,694	4,694	18
19	V	33 Real Estate Taxes				0		19
20	V	34 Rent-Facility & Grounds				7,918	7,918	20
21	V	35 Rent-Equipment & Vehicles				1,350	1,350	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		\$			\$ 21,762	\$ *	21,762 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: 01/01/08 Ending: 12/31/08

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					\$ 5,420	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	\$ 5,420		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: 01/01/08 Ending: 12/31/08

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 2,634	25	\$ 144,981	\$ 144,706	73	\$ 4,018	1
2	2	Food Purchase	Beds 2,634	25	0	0	73	0	2
3	3	Housekeeping	Beds 2,634	25	537	537	73	15	3
4	4	Laundry	Beds 2,634	25	0	0	73	0	4
5	5	Heat & Other Utilities	Beds 2,634	25	51,027	0	73	1,414	5
6	6	Maintenance	Beds 2,634	25	363,089	68,949	73	10,063	6
7	7	Other	Beds 2,634	25	0	0	73	0	7
8	9	Medical Director	Beds 2,634	25	59,193	0	73	1,641	8
9	10	Nursing & Medical Records	Beds 2,634	25	0	59,193	73	0	9
10	11	Activities	Beds 2,634	25	38,116	37,880	73	1,056	10
11	12	Social Service	Beds 2,634	25	0	0	73	0	11
12	13	Nurse Aide Training	Beds 2,634	25	30,133	29,953	73	835	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	1,835,880	1,835,880	73	50,881	15
16	18	Directors Fees	Beds 2,634	25	195,551	0	73	5,420	16
17	19	Professional Services	Beds 2,634	25	199,226	0	73	5,521	17
18	20	Fees, Subscription, Promotions	Beds 2,634	25	177,251	0	73	4,912	18
19	21	Clerical & General Office Expense	Beds 2,634	25	4,119,374	3,752,355	73	114,166	19
20	22	Employee Benefits & Payroll Tax	Beds 2,634	25	841,855	0	73	23,332	20
21	23	Inservice Training & Education	Beds 2,634	25	17,980	0	73	498	21
22	24	Travel and Seminar	Beds 2,634	25	263,598	0	73	7,305	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	292,705	0	73	8,112	24
25	TOTALS				\$ 8,630,496	\$ 5,929,453		\$ 239,189	25

Facility Name & ID Number COTILLION RIDGE NURSING CENTER

0045138

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	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	2,634	73	\$	\$	73	\$	1
2	30	Depreciation	Beds	2,634	73	281,453		73	7,800	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	73			73		3
4	32	Interest	Beds	2,634	73	169,367		73	4,694	4
5	33	Real Estate Taxes	Beds	2,634	73			73		5
6	34	Rent-Facility & Grounds	Beds	2,634	73	285,687		73	7,918	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	73	48,715		73	1,350	7
8	36	Other	Beds	2,634	73			73		8
9	38	Medically Nec Transportation	Beds	2,634	73			73		9
10	39	Ancillary Service Centers	Beds	2,634	73			73		10
11	40	Barber and Beauty Shops	Beds	2,634	73			73		11
12	41	Coffee and Gift Shops	Beds	2,634	73			73		12
13	42	Other	Beds	2,634	73			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					\$ 785,222	\$		\$ 21,762	25

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/08 Ending: 12/31/08

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 Community Bank		xx	Lease/Equipment Financing			\$ 1,000,000	\$ 10		variable	\$ 3,528	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 1,000,000	\$ 10			\$ 3,528	9								
B. Non-Facility Related*																				
10	Interest Income										(3,528)	10								
11	Allocated Corporate										4,694	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ 1,166	14								
15	TOTALS (line 9+line14)						\$ 1,000,000	\$ 10			\$ 4,694	15								

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

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

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

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

B. Real Estate Taxes

<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 2007 report.		\$ 19,786	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.)		\$ 12,958	2																													
3. Under or (over) accrual (line 2 minus line 1).		\$ (6,828)	3																													
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 13,606	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.		\$ 6,778	7																													
Real Estate Tax History:																																
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2003</td><td>17,140</td><td>8</td></tr> <tr><td>2004</td><td>17,374</td><td>9</td></tr> <tr><td>2005</td><td>20,243</td><td>10</td></tr> <tr><td>2006</td><td>17,871</td><td>11</td></tr> <tr><td>2007</td><td>6,778</td><td>12</td></tr> </table>	2003	17,140	8	2004	17,374	9	2005	20,243	10	2006	17,871	11	2007	6,778	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 2007 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>	FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2007 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2003	17,140	8																														
2004	17,374	9																														
2005	20,243	10																														
2006	17,871	11																														
2007	6,778	12																														
FOR BHF USE ONLY																																
13	FROM R. E. TAX STATEMENT FOR 2007 \$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>0727377025</u>	_____	\$ <u>12,790.00</u>	\$ <u>12,790.00</u>
2. <u>0727377024</u>	_____	\$ <u>168.00</u>	\$ <u>168.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>12,958.00</u>	\$ <u>12,958.00</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

X. BUILDING AND GENERAL INFORMATION:

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

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:

01/01/08

Ending:

12/31/08

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						7,800	7,800		34
35		Book Depreciation				39,397		39,397		244,715	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:

01/01/08

Ending:

12/31/08

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	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									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 812,226	\$ 39,397		\$ 47,197	\$ 7,800	\$ 244,715	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: 01/01/08 Ending: 12/31/08

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	\$ 535,832	\$ 9,952	\$ 9,952	\$		\$ 462,520	71
72	Current Year Purchases	11,951						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 547,783	\$ 9,952	\$ 9,952	\$		\$ 462,520	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)	\$ 1,361,009	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 49,349	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 57,149	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,800	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 707,235	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: 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. 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	\$ 312,300	10		3
4	Additions							4
5								5
6								6
7	TOTAL		73		\$ 312,300			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>/2009</u>	\$ <u>312,300</u>
13.	<u>/2010</u>	\$ <u>260,250</u>
14.	<u>/2011</u>	\$ <u>0</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: 1,550,000 *

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: \$ 7,012 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: 01/01/08 Ending: 12/31/08

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	\$		\$ 123,178	\$		\$ 123,178	1
2	Licensed Speech and Language Development Therapist		hrs			54,647			54,647	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			182,110	53		182,163	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				166,972		166,972	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					13,701			13,701	13
14	TOTAL			\$		\$ 373,636	\$ 167,025		\$ 540,661	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: **01/01/08**

Ending:

12/31/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/08**

(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	\$ 97,593	\$	1
2	Cash-Patient Deposits	1,933		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	499,357		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,198		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	151,902		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 780,983	\$	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	611,495		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	498,532		16
17	Accumulated Depreciation (book methods)	(707,235)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 403,792	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,184,775	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 127,559	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,933		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	44		31
32	Accrued Real Estate Taxes(Sch.IX-B)	13,606		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	IPA Tax	10,074		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 153,216	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	10		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)	\$ 10	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 153,226	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,031,549	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,184,775	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 914,675	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 914,675	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	256,874	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	(140,000)	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)	\$ 116,874	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,031,549	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER

0045138

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	\$ 4,048,115	1	
2	Discounts and Allowances for all Levels	(1,783,486)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,264,629	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	1,529,935	6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,529,935	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	16,045	13	
14	Non-Patient Meals		14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	296,555	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory		19	
20	Radiology and X-Ray		20	
21	Other Medical Services	2,689	21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 315,289	23	
D. Non-Operating Revenue				
24	Contributions	(1,400)	24	
25	Interest and Other Investment Income***	4,479	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,079	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)	\$ 4,112,932	30	

		2		
Expenses		Amount		
A. Operating Expenses				
31	General Services	649,523	31	
32	Health Care	1,853,799	32	
33	General Administration	958,535	33	
B. Capital Expense				
34	Ownership	378,967	34	
C. Ancillary Expense				
35	Special Cost Centers	15,234	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)*	\$ 3,856,058	40	
41	Income before Income Taxes (line 30 minus line 40)**	256,874	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 256,874	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: **01/01/08**

Ending:

12/31/08

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	1,960	2,072	\$ 50,549	\$ 24.40	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	5,547	6,603	137,123	20.77	3
4	Licensed Practical Nurses	11,398	11,774	228,179	19.38	4
5	CNAs & Orderlies	54,596	58,723	620,644	10.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,109	4,556	81,265	17.84	8
9	Activity Director					9
10	Activity Assistants	3,622	3,814	36,429	9.55	10
11	Social Service Workers	1,776	2,078	28,674	13.80	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,057	16,974	153,766	9.06	15
16	Dishwashers					16
17	Maintenance Workers	3,312	3,643	52,678	14.46	17
18	Housekeepers	8,277	8,724	74,398	8.53	18
19	Laundry	2,914	3,138	40,330	12.85	19
20	Administrator	1,900	2,080	76,578	36.82	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,291	8,380	123,937	14.79	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)	122,759	132,559	\$ 1,704,550 *	\$ 12.86	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		885		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		5,707		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 20,782		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: **01/01/08**

Ending: **12/31/08**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Roxanne Summers	admin	0	\$ 76,578	Workers' Compensation Insurance	\$ 47,205	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	26,620	Advertising: Employee Recruitment	3,884	
				FICA Taxes	130,398	Health Care Worker Background Check		
				Employee Health Insurance	110,185	(Indicate # of checks performed)	1,410	
				Employee Meals		Patient Background Checks	4,912	
				Illinois Municipal Retirement Fund (IMRF)*			13,600	
					0		2,880	
					17,712		5,335	
					23,332		1,315	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 76,578			Less: Public Relations Expense	(2,880)	
(List each licensed administrator separately.)						Non-allowable advertising	(573)	
						Yellow page advertising	(13,600)	
B. Administrative - Other								
Description			Amount			TOTAL (agree to Sch. V, line 20, col. 8)		
			\$				\$ 17,278	
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Heritage Operations Group			\$ 249,407				Out-of-State Travel	\$
Sulaski & Webb			13,300					
			0				In-State Travel	
			0					606
								0
							Seminar Expense	4,171
								(10,083)
			0				Central Office	7,305
			630					
			0				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)			\$ 263,337	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 1,999
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

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? 7 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 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. \$ 1,166
- (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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ 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.

