

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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 Ctr

Address: 600 E Robinwood Dr Robinson 62454
Number City Zip Code

County: Crawford

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

HFS ID Number:

Date of Initial License for Current Owners: 2000

Type of Ownership:

☐ VOLUNTARY,NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 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)
(Type or Print Name) Craig Ater
(Title) Exec VP & CFO

Paid
Preparer

(Signed)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Cotillion Ridge Nursing Ctr# 0045138 Report Period Beginning: 01/01/12 Ending: 12/31/12

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>26,718</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>26,718</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>14,454</u>	<u>6,867</u>	<u>2,817</u>	<u>24,138</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>14,454</u>	<u>6,867</u>	<u>2,817</u>	<u>24,138</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 90.34%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

none

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

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 _____ 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 2,817Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL ☒ 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.

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	171,447	11,639		183,086		183,086	4,524	187,610		1
2	Food Purchase		158,466		158,466		158,466	33	158,499		2
3	Housekeeping	105,778	32,431		138,209		138,209		138,209		3
4	Laundry	71,547	13,606		85,153		85,153		85,153		4
5	Heat and Other Utilities			64,761	64,761		64,761	1,079	65,840		5
6	Maintenance	42,624	26,972	60,028	129,624		129,624	11,139	140,763		6
7	Other (specify):*										7
8	TOTAL General Services	391,396	243,114	124,789	759,299		759,299	16,775	776,074		8
	B. Health Care and Programs										
9	Medical Director			16,500	16,500		16,500	1,895	18,395		9
10	Nursing and Medical Records	1,099,463	78,226	4,971	1,182,660		1,182,660	1	1,182,661		10
10a	Therapy		260,787	472,065	732,852	(278,878)	453,974	42,244	496,218		10a
11	Activities	36,965	2,080		39,045		39,045		39,045		11
12	Social Services	29,562	128	5,039	34,729		34,729		34,729		12
13	CNA Training							755	755		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,165,990	341,221	498,575	2,005,786	(278,878)	1,726,908	44,895	1,771,803		16
	C. General Administration										
17	Administrative	77,189			77,189		77,189		77,189		17
18	Directors Fees										18
19	Professional Services			225,301	225,301		225,301	(198,318)	26,983		19
20	Dues, Fees, Subscriptions & Promotions			67,114	67,114	(40,077)	27,037	(6,779)	20,258		20
21	Clerical & General Office Expenses	153,860	22,835	5,152	181,847		181,847	205,504	387,351		21
22	Employee Benefits & Payroll Taxes			376,977	376,977		376,977	29,176	406,153		22
23	Inservice Training & Education			2,869	2,869		2,869	(870)	1,999		23
24	Travel and Seminar			7,584	7,584		7,584	(5,585)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			53,005	53,005		53,005	7,953	60,958		26
27	Other (specify):*			12,069	12,069		12,069	(12,000)	69		27
28	TOTAL General Administration	231,049	22,835	750,071	1,003,955	(40,077)	963,878	19,081	982,959		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,788,435	607,170	1,373,435	3,769,040	(318,955)	3,450,085	80,751	3,530,836		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			160,361	160,361		160,361	12,349	172,710			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			140,253	140,253		140,253	(694)	139,559			32
33	Real Estate Taxes			22,614	22,614		22,614	31	22,645			33
34	Rent-Facility & Grounds							4,619	4,619			34
35	Rent-Equipment & Vehicles			8,650	8,650		8,650	713	9,363			35
36	Other (specify):*											36
37	TOTAL Ownership			331,878	331,878		331,878	17,018	348,896			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					278,878	278,878		278,878			39
40	Barber and Beauty Shops			15,194	15,194		15,194		15,194			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					40,077	40,077		40,077			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			15,194	15,194	318,955	334,149		334,149			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,788,435	607,170	1,720,507	4,116,112		4,116,112	97,769	4,213,881			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(978)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(870)			16
17	Non-Care Related Fees	(350)			17
18	Fines and Penalties				18
19	Entertainment	(8,322)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,660)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)			24
25	Fund Raising, Advertising and Promotional	(11,885)			25
	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (38,065)		\$	30

BHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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)	135,834		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 135,834		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 97,769		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

Cotillion Ridge Nursing CtrID# 0045138Report Period Beginning: 01/01/12Ending: 12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5		0	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(350)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(3,660)	19	22
23				23
24		(12,000)	27	24
25		(11,885)	20	25
26				26
27				27
28				28
29			33	29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(27,895)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Cotillion Ridge Nursing Ctr # 0045138 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	4,524	0	0	0	0	0	0	0	0	4,524	1
2	Food Purchase	0	0	33	0	0	0	0	0	0	0	0	33	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	1,079	0	0	0	0	0	0	0	0	1,079	5
6	Maintenance	0	0	11,139	0	0	0	0	0	0	0	0	11,139	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	16,775	0	0	0	0	0	0	0	0	16,775	8
	B. Health Care and Programs													
9	Medical Director	0	0	1,895	0	0	0	0	0	0	0	0	1,895	9
10	Nursing and Medical Records	0	0	1	0	0	0	0	0	0	0	0	1	10
10a	Therapy	0	42,244	0	0	0	0	0	0	0	0	0	42,244	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	755	0	0	0	0	0	0	0	0	755	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	42,244	2,651	0	0	0	0	0	0	0	0	44,895	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,660)	(206,641)	11,983	0	0	0	0	0	0	0	0	(198,318)	19
20	Fees, Subscriptions & Promotions	(12,235)	0	5,456	0	0	0	0	0	0	0	0	(6,779)	20
21	Clerical & General Office Expenses	0	0	205,504	0	0	0	0	0	0	0	0	205,504	21
22	Employee Benefits & Payroll Taxes	0	0	29,176	0	0	0	0	0	0	0	0	29,176	22
23	Inservice Training & Education	(870)	0	0	0	0	0	0	0	0	0	0	(870)	23
24	Travel and Seminar	(8,322)	0	2,737	0	0	0	0	0	0	0	0	(5,585)	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	7,953	0	0	0	0	0	0	0	0	7,953	26
27	Other (specify):*	(12,000)	0	0	0	0	0	0	0	0	0	0	(12,000)	27
28	TOTAL General Administration	(37,087)	(206,641)	262,809	0	0	0	0	0	0	0	0	19,081	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(37,087)	(164,397)	282,235	0	0	0	0	0	0	0	0	80,751	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Cotillion Ridge Nursing Ctr # 0045138 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	12,349	0	0	0	0	0	0	0	12,349	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(978)	0	0	284	0	0	0	0	0	0	0	(694)	32
33	Real Estate Taxes	0	0	0	31	0	0	0	0	0	0	0	31	33
34	Rent-Facility & Grounds	0	0	0	4,619	0	0	0	0	0	0	0	4,619	34
35	Rent-Equipment & Vehicles	0	0	0	713	0	0	0	0	0	0	0	713	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(978)	0	0	17,996	0	0	0	0	0	0	0	17,018	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)	(38,065)	(164,397)	282,235	17,996	0	0	0	0	0	0	0	97,769	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Heritage Enterprises, Inc.	100	See Pg 25				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$		1
2	V	10a	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	42,244	42,244	2
3	V								3
4	V	19	Adjustment for Related Organization	206,641	Heritage Operations Group, LLC	0.00%		(206,641)	4
5	V								5
6	V	34	Adjustment for Related Organization	0	Heritage Manor Real Estate, LLC	0.00%			6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				10
11	V								11
12	V								12
13	V								13
14	Total			\$ 206,641			\$ 42,244	\$ * (164,397)	14

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Heritage Enterprises, Inc.		\$	4,524	15
16	V	2	Food Purchase					33	16
17	V	3	Housekeeping					0	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,079	19
20	V	6	Maintenance					11,139	20
21	V	7	Other					0	21
22	V	9	Medical Director					1,895	22
23	V	10	Nursing & Medical Records					1	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					755	26
27	V	14	Program Transportation					0	27
28	V	15	Other					0	28
29	V	17	Administrative					0	29
30	V	18	Directors Fees					0	30
31	V	19	Professional Services					11,983	31
32	V	20	Fees, Subscription, Promotions					5,456	32
33	V	21	Clerical & General Office Expenses					205,504	33
34	V	22	Employee Benefits & Payroll Taxes					29,176	34
35	V	23	Inservice Training & Education					0	35
36	V	24	Travel and Seminar					2,737	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					7,953	38
39	Total			\$			\$ 0	\$ * 282,235	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	\$	Heritage Enterprises, Inc.		\$	0	15
16	V	30	Depreciation					12,349	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					284	18
19	V	33	Real Estate Taxes					31	19
20	V	34	Rent-Facility & Grounds					4,619	20
21	V	35	Rent-Equipment & Vehicles					713	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	\$ * 17,996	39

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Heritage Enterprises Inc.	Member		100.00					\$ 0	0	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Cotillion Ridge Nursing Ctr # 0045138 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,735	26	\$ 169,500	\$ 168,827	73	\$ 4,524	1
2	2	Food Purchase	Beds	2,735	26	1,241	0	73	33	2
3	3	Housekeeping	Beds	2,735	26	0	0	73	0	3
4	4	Laundry	Beds	2,735	26	0	0	73	0	4
5	5	Heat & Other Utilities	Beds	2,735	26	40,426	0	73	1,079	5
6	6	Maintenance	Beds	2,735	26	417,328	78,403	73	11,139	6
7	7	Other	Beds	2,735	26	0	0	73	0	7
8	9	Medical Director	Beds	2,735	26	71,007	0	73	1,895	8
9	10	Nursing & Medical Records	Beds	2,735	26	33	70,119	73	1	9
10	11	Activities	Beds	2,735	26	0	0	73	0	10
11	12	Social Service	Beds	2,735	26	0	0	73	0	11
12	13	Nurse Aide Training	Beds	2,735	26	28,290	22,496	73	755	12
13	14	Program Transportation	Beds	2,735	26	0	0	73	0	13
14	15	Other	Beds	2,735	26	0	0	73	0	14
15	17	Administrative	Beds	2,735	26	0	0	73	0	15
16	18	Directors Fees	Beds	2,735	26	0	0	73	0	16
17	19	Professional Services	Beds	2,735	26	448,954	0	73	11,983	17
18	20	Fees, Subscription, Promotions	Beds	2,735	26	204,427	0	73	5,456	18
19	21	Clerical & General Office Expenses	Beds	2,735	26	7,699,360	7,229,609	73	205,504	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,735	26	1,093,087	0	73	29,176	20
21	23	Inservice Training & Education	Beds	2,735	26	0	0	73	0	21
22	24	Travel and Seminar	Beds	2,735	26	102,532	0	73	2,737	22
23	25	Other Admin. Staff Transportation	Beds	2,735	26	0	0	73	0	23
24	26	Insurance-Prop.Liab.Malpractice	Beds	2,735	26	297,962	0	73	7,953	24
25	TOTALS					\$ 10,574,147	\$ 7,569,454		\$ 282,235	25

Facility Name & ID Number Cotillion Ridge Nursing Ctr # 0045138 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,735	26	\$		73	\$	1
2	30	Depreciation	Beds	2,735	26	462,659		73	12,349	2
3	31	Amortization of Pre-Op & Org	Beds	2,735	26			73		3
4	32	Interest	Beds	2,735	26	10,650		73	284	4
5	33	Real Estate Taxes	Beds	2,735	26	1,164		73	31	5
6	34	Rent-Facility & Grounds	Beds	2,735	26	173,045		73	4,619	6
7	35	Rent-Equipment & Vehicles	Beds	2,735	26	26,702		73	713	7
8	36	Other	Beds	2,735	26			73		8
9	38	Medically Nec Transportation	Beds	2,735	26			73		9
10	39	Ancillary Service Centers	Beds	2,735	26			73		10
11	40	Barber and Beauty Shops	Beds	2,735	26			73		11
12	41	Coffee and Gift Shops	Beds	2,735	26			73		12
13	42	Other	Beds	2,735	26			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					\$ 674,220	\$		\$ 17,996	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	Morton Community Bank		x	Mortgage			\$	2,322,454			\$	134,699	1						
2	Morton Community Bank		x	Loan Fee Amort								5,554	2						
3													3						
4													4						
5													5						
	Working Capital																		
6	Morton Community Bank		xx	Working Capital									6						
7													7						
8													8						
9	TOTAL Facility Related						\$	2,322,454				\$	140,253	9					
	B. Non-Facility Related*																		
10	Interest Income											(978)	10						
11													11						
12	Allocated Corporate											284	12						
13													13						
14	TOTAL Non-Facility Related						\$					\$	(694)	14					
15	TOTALS (line 9+line14)						\$	2,322,454				\$	139,559	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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																							
1. Real Estate Tax accrual used on 2011 report.			\$	21,678	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.)			\$	21,606	2																				
3. Under or (over) accrual (line 2 minus line 1).			\$	(72)	3																				
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	22,686	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.			\$	22,614	7																				
Real Estate Tax History:																									
Real Estate Tax Bill for Calendar Year:	2007	17,871	8	<table><tr><td></td><td colspan="2">FOR BHF USE ONLY</td><td></td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2011</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 2011	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
	FOR BHF USE ONLY																								
13	FROM R. E. TAX STATEMENT FOR 2011	\$	13																						
14	PLUS APPEAL COST FROM LINE 5	\$	14																						
15	LESS REFUND FROM LINE 6	\$	15																						
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																						
	2008	6,778	9																						
	2009	24,295	10																						
	2010	21,563	11																						
	2011	22,614	12																						

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.**

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Cotillion Ridge Nursing Ctr

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 2011 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 2011.

(A)		(B)	(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	05427033042000		\$ 21,306.00	\$ 21,306.00
2.	05427033041000		\$ 300.00	\$ 300.00
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 21,606.00	\$ 21,606.00

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 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				\$ 26,000	1
2					2
3	TOTALS			\$ 26,000	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	73				\$ 1,525,000	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Acquisition of Building Improvements from prior Operator			2001	154,177					9
10										10
11	Dinning Room/Day Room Addition---Outside Contractor			2001	164,291					11
12	Dinning Room/Day Room Addition---Design			2001	50,288					12
13	Dinning Room/Day Room Addition---Wallcoverings			2001	9,670					13
14										14
15	Dinning Room/Day Room Addition---Outside Contractor			2002	66,633					15
16	Dinning Room/Day Room Addition---Design			2002	4,665					16
17	Heating Duct Replacement			2002	12,146					17
18										18
19	Dinning Room/Day Room Addition---Paid by ProCare			2002	200,750					19
20	directly to General Contractor									20
21										21
22	Heat Pump			2003	12,720					22
23	Compressor			2003	1,333					23
24	A/C Unit			2003	2,569					24
25	Water Heater			2003	7,262					25
26	Sprinkler Head Replacements			2003	3,993					26
27	Asphalt Sealing			2003	1,260					27
28	idph			2003	8,618					28
29										29
30	Rewire Resident Rooms			2004	3,250					30
31										31
32										32
33	C/O Allocation					12,349			(12,349)	33
34	Book Depreciation					113,576		113,576		34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Parking Lot Sealer	2005	\$ 1,260	\$		\$	\$	\$	37
38	Doors	2005	660						38
39	A/C compressor	2005	983						39
40	Sidewalk	2005	7,898						40
41	Ansul System	2005	1,990						41
42									42
43	Furnace	2006	4,850						43
44	Roof	2006	7,230						44
45	A/C compressor	2006	1,354						45
46	Water line	2006	1,119						46
47									47
48	A/C	2007	6,406						48
49	Parking Lot	2007	36,176						49
50									50
51	CC TV system	2008	3,397						51
52	Parking Lot	2008	15,919						52
53	Hallway Painting	2008	5,325						53
54	Landscaping	2008	9,896						54
55	Exit Doors	2008	4,138						55
56									56
57									57
58	Furnace	2009	7,443						58
59	Dumpster Pad	2009	3,400						59
60	Parking Lot	2009	2,619						60
61	Door Closers	2009	4,465						61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,355,153	\$ 125,925		\$ 113,576	\$ (12,349)	\$	70

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,355,153	\$ 125,925		\$ 113,576	\$ (12,349)	\$	1
2									2
3	General Conditions & Demolition	2009	73,230						3
4	Carpentry & Millwork	2009	45,270						4
5	Acoustical Ceiling & Flooring	2009	49,176						5
6	Painting	2009	36,800						6
7	Plumbing	2009	10,600						7
8	Electrical	2009	18,430						8
9	Design and layout	2009	13,837						9
10	Project Materials	2009	99,339						10
11	Interior Doors and toilets & related hardware	2009	67,621						11
12	Flooring Central Core	2009	23,320						12
13									13
14	Service sink	2010	5,225						14
15	AHU replacement	2010	4,934						15
16									16
17	Window treatments & tile	2011	4,481						17
18	Walk-in cooler	2011	38,164						18
19									19
20	Water Heater	2012	14,802						20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,860,382	\$ 125,925		\$ 113,576	\$ (12,349)	\$	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,860,382	\$ 125,925		\$ 113,576	\$ (12,349)		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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,860,382	\$ 125,925		\$ 113,576	\$ (12,349)		34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,860,382	\$ 125,925		\$ 113,576	\$ (12,349)		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
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,860,382	\$ 125,925		\$ 113,576	\$ (12,349)		34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$837,761	\$46,785	\$46,785	\$		\$	71
72	Current Year Purchases	3,881						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$841,642	\$46,785	\$46,785	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$3,728,024	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$172,710	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$160,361	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(12,349)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

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

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$8,650
- 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

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES
☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM
IN OTHER FACILITY
COMMUNITY COLLEGE
HOURS PER CNA

☐
☐
☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM
IN OTHER FACILITY
HOURS PER CNA

☐
☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

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

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.)

12345678										
	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	\$		\$ 147,497	\$		\$ 147,497	1
2	Licensed Speech and Language Development Therapist		hrs			60,389			60,389	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			245,786	302		246,088	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				260,485		260,485	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					18,393			18,393	13
14	TOTAL			\$		\$ 472,065	\$ 260,787		\$ 732,852	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.

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 882,624	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 882,624	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	6,457	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 6,457	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)	\$ 889,081	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Cotillion Ridge Nursing Ctr# 0045138Report Period Beginning: 01/01/12Ending: 12/31/12

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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,679,304	1
2	Discounts and Allowances for all Levels	(1,625,422)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,053,882	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,576,891	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,576,891	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	16,305	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	474,212	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	301	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 490,818	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	978	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 978	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)	\$ 4,122,569	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	759,299	31
32	Health Care	2,005,786	32
33	General Administration	1,003,955	33
	B. Capital Expense		
34	Ownership	331,878	34
	C. Ancillary Expense		
35	Special Cost Centers	15,194	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,116,112	40
41	Income before Income Taxes (line 30 minus line 40)**	6,457	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 6,457	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

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

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

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

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

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	1,600	1,785	\$ 60,318	\$ 33.79	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	11,242	11,643	255,418	21.94	3
4	Licensed Practical Nurses	6,992	7,470	141,546	18.95	4
5	CNAs & Orderlies	48,208	51,877	561,563	10.82	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,902	4,143	80,618	19.46	8
9	Activity Director					9
10	Activity Assistants	3,274	3,537	36,965	10.45	10
11	Social Service Workers	1,920	2,032	29,562	14.55	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,960	18,280	171,447	9.38	15
16	Dishwashers					16
17	Maintenance Workers	3,490	3,788	42,624	11.25	17
18	Housekeepers	10,846	11,468	105,778	9.22	18
19	Laundry	6,347	6,815	71,547	10.50	19
20	Administrator	1,950	2,080	77,189	37.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,257	8,050	153,860	19.11	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)	123,988	132,968	\$ 1,788,435 *	\$ 13.45	34

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		16,500		36
37	Medical Records Consultant		400		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,380		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		5,039		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 26,319		49

C. CONTRACT NURSES

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

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

** See instructions.

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			\$ 77,189	Workers' Compensation Insurance		\$ 37,905	IDPH License Fee	\$ 0		
				Unemployment Compensation Insurance		40,679	Advertising: Employee Recruitment	2,977		
				FICA Taxes		136,815	Health Care Worker Background Check (Indicate # of checks performed _____)	2,066		
				Employee Health Insurance		148,930	Patient Background Checks			
				Employee Meals						
				Illinois Municipal Retirement Fund (IMRF)*		0		3,150		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 77,189	Other Benefits		12,648	Dues & Subscriptions	4,737		
B. Administrative - Other				Central Office Allocation		29,176	License & Fees	5,372		
Description			Amount				Central Office Allocation	5,456		
			\$				Less: Public Relations Expense	(3,150)		
							Non-allowable advertising	(350)		
							Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 406,153	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 20,258
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	Mgt		\$ 206,641			\$	Out-of-State Travel	\$		
			0							
Sulaski & Webb	Audit		15,000							
							In-State Travel			
								6,721		
								54		
							Seminar Expense	809		
								(5,585)		
Legal adj to Zero			3,660				Entertainment Expense	()		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 225,301	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 1,999

*** Attach copy of IMRF notifications**

****See instructions.**

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

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

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

no
- (2)

Are there any dues to nursing home associations included on the cost report?

yes

If YES, give association name and amount.

Illinois Health Care Association
- (3)

Did the nursing home make political contributions or payments to a political action organization?

yes

If YES, have these costs been properly adjusted out of the cost report?

yes
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

no

If YES, what is the capacity?
- (5)

Have you properly capitalized all major repairs and equipment purchases?

yes

What was the average life used for new equipment added during this period?

7 years
- (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?

If YES, give effective date of lease.
- (9)

Are you presently operating under a sublease agreement?

YES

x

NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

x

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 40,077

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.

\$ 933
- (16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

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?

yes

g. Does the facility transport residents to and from day training?

no

Indicate the amount of income earned from providing such transportation during this reporting period.

\$
- (17)

Has an audit been performed by an independent certified public accounting firm?

yes

Firm Name:

Sulaski & Webb
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out 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.

Account Number	Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg Line #	Adjustment Amount		
1009	PETTY CASH	188,663				1,009		1,009	PETTY C 188,663
1010	CASH IN BANK					1,100		1,100	ACCTS R 853,163
1040	CASH IN BANK-PAYROLL					1,101		1,101	ALLOW. FOR UNCOLLECTIBI
1100	ACCOUNTS RECEIVABLE	853,163				1,110		1,110	ACCTS RECEIV-M/C
1110	MEDICARE RECEIVABLES					1,125		1,125	ACCTS RECEIV-IPA
1125	IPA INCOME RECEIVABLE					1,135		1,135	ACCTS RECEIV-IC
1130	MEDICARE COST REPORT					1,140		1,140	UNAPPLIED CASH RECEIPTS
1135	ACCOUNTS RECEIVABLE-IC					1,145		1,145	A/R SUSPENSE-REFUNDS
1140	UNAPPLIED CASH RECEIPTS					1,200		1,200	PREPAID 29,674
1145	A/R SUSPENSE-REFUNDS					1,220		1,220	OTHER PREPAID EXPENSES
1190	ACCRUED INTEREST REC					1,300		1,300	DIETARY INVENTORY
1200	PREPAID INSURANCE	29,674				1,310		1,310	SUPPLIES INVENTORY
1220	OTHER PREPAID EXPENSES					1,320		1,320	LINEN INVENTORY
1300	FOOD INVENTORY					1,409		1,409	LAND 26,000
1310	SUPPLIES INVENTORY					1,450		1,450	FURNITU 790,786
1409	LAND	26,000				1,460			(590,633)
1450	FURNITURE & EQUIPMENT	790,786				1,475		1,475	CODE AI 2,668,126
1460	ACCUM DEPR-FURN & EQU	-590,633				1,490		1,490	ACCUM I (589,178)
1475	BUILDING & IMPROVEMEN	2,668,126				1,530		1,530	RESIDEN 4,582
1490	ACCUM DEPR-BUILDING	-589,178				1,550		1,550	LOAN FE 15,137
1530	RESIDENT FUNDS	4,582				1,551		1,551	LOAN FEES ADDED
1550	LOAN FEES	15,137				1,850		1,850	INTERCC 158,372
1560	REAL ESTATE TAX ESCROW					2,010		2,010	ACCOUN (216,428)
1575	REIMBURSABLE PURCHASES					2,100		2,095	BONUSES PAYABLE
1850	INTRACOMPANY	158,372				2,100		2,100	ACCRUE 0
2010	ACCOUNTS PAYABLE	-216,428				2,100		2,100	PR CLEARING-BENEFITS
2095	BONUSES PAYABLE					2,100		2,100	PR CLEARING-LABOR
2100	ACCRUED PAYROLL	0				2,110		2,110	ACCRUE 0
2110	ACCRUED VACATION PAY	0				2,120		2,120	U.C. TAXES PAYABLE

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	0
2125	FICA TAX PAYABLE	0	0	2,130	2,130 FEDERAL W/H TAX PAYABLE	
2130	FIT PAYABLE			2,140	2,140 STATE W/H TAX PAYABLE	
2140	STATE W/H PAYABLE		0	2,152	2,152 WORKERS COMP ACCRUAL	
2145	EARNED INCOME CREDIT			2,225	2,225 EMPLOYEE INSURANCE RE	
2150	UC FED CREDIT REDUCTION			2,230	2,230 PAYROLL SAVINGS	
2230	PAYROLL SAVINGS			2,235	2,240 UNITED FUND	
2235	IRA W/HOLDINGS			2,240	2,246 GROUP INSURANCE - CAFETI	
2240	UNITED WAY			2,246	2,250 401K W/H	
2245	GROUP INSURANCE PAYABLE			2,250		
2246	GROUP INSURANCE PAYABLE-CAFETERIA			2,260	2,260 WAGE GARNISHMENT	
2260	WAGE GARNISHMENTS			2,300	2,300 ACCRUE	(1,074)
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYI	(98,387)
2300	ACCRUED INTEREST PAYA	-1,074		2,350	2,350 REAL ES	(22,686)
2310	SALES TAX PAYABLE			2,385		0
2320	IPA PAYMENTS PAYABLE	-98,387		2,400	2,400 CURRENT PORTION OF LT DI	
2350	REAL ESTATE TAX PAYAB	-22,686		2,512	2,512 DUE TO I	(4,582)
2385	ACTIVITY FUND	0		2,600	2,600 LASALLI	(2,322,454)
2390	SECURITY DEPOSITS	0		2,600		
2391	VOLUNTEER FUND			2,625	2,625 LASALLE CONSTR. LOAN #2	
2393	HEART FUND/BAZAAR			2,625		
2395	DEFERRED INC EMP & MEM			2,695	2,695 CURRENT PORTION OF LT DI	
2400	CURRENT PORTION LT DEBT			2,720	2,720 RETAINE	(882,624)
2460	INCOME TAXES PAYABLE				net incom	(6,457)
2512	DUE TO RESIDENTS	-4,582				
2600	MORTGAGE PAYABLE	-2,322,454				
2650	EQUIPMENT LOAN PAYABLE				balance	<u>0</u>
2695	CURRENT PORTION LT DEBT					
2696	DEFERRED INCOME TAXES					
2710	COMMON STOCK					
2720	RETAINED EARNINGS	-882,624				
2970	PROFIT/LOSS FOR PERIOD	-6,457				
3007.1	PATIENT DAYS-PRIVATE	6,867				3,007

3007.2	PATIENT DAYS-IPA	14,454						3,007
3007.3	PATIENT DAYS-MEDICARE	2,817						3,007
3007.4	PATIENT DAYS-CONVERSION							3,007
3007.5	PATIENT DAYS-LICENSED							3,007
3007.6	PATIENT DAYS-TOTAL							3,007
3010	1 BASIC CHARGE-PRIVATE &	-3,664,554	0	0	0	0		3,007
3015	1 PRIVATE ASSESSMENT TAX INCOME		0	0	0	0		3,010
3020	1 BASIC CHARGE-IPA	0	0	0	0	0		3,020
3030	1 BASIC CHARGE-MEDICARI	0	0	0	0	0		3,030
3035	4 DAY CARE/HOME CARE		0	0	0	0		3,040
3040	1 LIGHT NURSING CARE	0	0	0	0	0		3,050
3050	1 MEDIUM NURSING CARE		0	0	0	0		3,060
3060	1 HEAVY NURSING CARE		0	0	0	0		3,061
3061	1 SKILLED NURSING CARE							3,080
3080	1 NURSING SUPPLIES-PRIVA	0	0	0	0	0		3,081
3081	1 NURSING SUPPLIES-IPA		0	0	0	0		3,082
3082	1 NURSING SUPPLIES MED PT A		0	0	0	0		3,083
3083	1 NURSING SUPPLIES MED PT B							3,100
3100	17 DRUGS	-474,212	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-1,576,891	0	0	0	0		3,111
3111	6 PT-IPA		0	0	0	0		3,112
3112	6 PT-MEDICARE PART A		0	0	0	0		3,113
3113	6 PT-MEDICARE PART B		0	0	0	0		3,140
3130	1 PUBLIC AID ASSESSMENT INC							3,150
3140	19 LABORATORY INCOME		0	0	0	0		3,151
3150	6 SPEECH/OT-PRIVATE		0	0	0	0		3,152
3151	6 SPEECH/OT-IPA		0	0	0	0		3,153
3152	6 SPEECH/OT-MED PART A		0	0	0	0		3,160
3153	6 SPEECH/OT MED PART B							3,410
3410	2 IPA DISCOUNTS	1,625,422	0	0	0	0		3,411
3411	2 MEDICAID PART B DISCOUNT		0	0	0	0		3,420
3420	2 MEDICARE DISCOUNTS		0	0	0	0		3,500

3440	36 ASSESSMENT TAX EXPENSE			42	3	0	0	3,520
3520	16 RENT INCOME	0		6	0	6	0	3,530
3530	13 BEAUTY SHOP	-16,305		0	0	0	0	3,560
3560	12 ACTIVITY FUND INCOME	0		0	0	0	0	3,570
3570	12 VENDING INCOME/EXPENSE	0		0	0	0	0	3,590
3580	12 MANAGEMENT FEES			0	0	0	0	3,595
3590	1 EQUIPMENT RENTAL	-14,750		0	0	0	0	3,600
3595	21 RESIDENT TRANSPORTATION	-301		0	0	0	0	4,110
3600	21 MISC INCOME	0		0	0	0	0	4,111
4110	GENERAL & ADMINISTRATIVE WAGES	143,072	153,860	21	1	17	0	4,115
4111	ADMINISTRATOR WAGES	77,189	77,189	17	1	0	0	4,120
4115	VACATION & SICK - G&A	10,788		21	1	0	0	4,125
4120 4475	EMPLOYEE BENEFITS	13,853	376,977	22	3	0	0	4,130
4125	EMPLOYEE HEPETITIS VACATION	0		22	3	0	0	4,135
4130	EMPLOYEE SCHOLORSHIP	0		21	1	0	0	4,250
4135	EMPLOYEE SCHOLORSHIP	-1,205		23	3	0	0	4,255
4220	DIRECTORS FEES	0	0	18	3	0	0	4,260
4250 4255	OFFICE SUPPLIES	22,835	22,835	21	2	0	0	4,275
4260	TELEPHONE	5,152	5,152	21	3	0	0	4,276
4275	TRAINING & EMPLOYEE DEVELOPMENT	2,869	2,869	23	3	16	-870 **	4,280
4280	GENERAL TRAVEL	6,721	7,584	24	3	16	0	4,281
4281	MEAL EXPENSE FOR TRAVEL	54		24	3	19	0	4,285
4285	EDUCATION & SEMINAR	809		24	3	19	-8,322 ***	4,289
4290	HELP WANTED ADVERTISING	2,977	67,114	20	3	0	0 -40,077	4,290
4291	PROMOTIONAL ADVERTISING	8,735		20	3	25	-8,735	4,291
4292	PUBLIC RELATIONS	3,150		20	3	25	-3,150	4,292
4300	LICENSES & FEES	45,449		20	3	17	0	4,300
4310	DUES & SUBSCRIPTIONS	4,737		20	3	17	-350	4,310
4320	CONTRIBUTIONS	0		27	3	20	0	4,320
4350	PROFESSIONAL FEES	18,660	225,301	19	3	22	-3,660	4,350
4355	MEDICAL DIRECTOR	16,500	16,500	9	3	0	0	4,355
4360	UTILIZATION REVIEW	0		10	3	0	0	4,362
4361	OTHER PHYSICIAN FEES			39	3	0	0	4,363

4362	MEDICAL RECORDS CONSULT	400		10	3	0	0	4,364
4363	PHARMACIST FEES	4,380		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	5,039	5,039	12	3	0	0	4,383
4370	TV RENTAL	-1,212		35	3	5	0	4,390
4380	INCOME TAXES		12,069	27	3	26	0	4,400
4383	BACKGROUND CHECKS	2,066		20	3	26	0	4,401
4400	PAYROLL TAXES	169,482		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	8,012		22	3	0	0	4,420
4410	GROUP INSURANCE	148,930		22	3	0	0	4,430
4420	LIABILITY INSURANCE	53,005	53,005	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSUR/	37,905		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	206,641		19	3	34	0 **	4,460
4460	BAD DEBTS	12,000		27	3	24	-12,000	4,461
4470	LOST ITEMS-RESIDENTS	69		27	3	0		4,470
4490	MISCELLANEOUS	0		27	3	0	0	4,475
4510	REAL ESTATE TAXES	22,614	22,614	33	3	0	0	4,486
4600	LEASED EQUIPMENT	9,862	8,650	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	41,687	42,624	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	937		6	1	0	0	4,510
5130	ELECTRIC	37,134	64,761	5	3	0	0	4,600
5131	NATURAL GAS	12,030		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	15,597		5	3	0	0	5,130
5134	TRASH COLLECTION	27,618	60,028	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	3,815	26,972	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN	23,157		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC	32,410		6	3	0	0	5,140
5210	DIETARY WAGES	166,215	171,447	1	1	0	0	5,160
5220	DIETARY SICK & VAC	5,232		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	159,399	158,466	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	3,215	11,639	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	1,331		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	7,093		1	2	0	0	5,260
5295	MEAL CREDIT	-933		2	2	0	0	5,270
5310	LAUNDRY WAGES	67,399	71,547	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	4,148		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	7,408	13,606	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	6,198		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	101,972	105,778	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	3,806		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	166	32,431	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	32,265		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,099,463	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	243,551		10	1	0	0	6,020
6030	DON WAGES	60,318		10	1	0	0	6,030
6035	ADON	0		10	1	0	0	6,035
6040	RN SICK & VACATION	11,867		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	136,440		10	1	0	0	6,120
6120	LPN WAGES-NON MEDICAL	0		10	1	0	0	6,140
6130	LPN WAGES OTHER			10	1	0	0	6,220
6140	LPN SICK & VACATION	5,106		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICAL	542,733		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	18,830		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	0		10	3	0	0	6,255
6246	CONTRACT NURSES-LPN	0		10	3	0	0	6,260
6247	CONTRACT NURSES-AIDES	0		10	3	0	0	6,270
6250	NURSE AIDE TRAINING W/	0	0	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	0	0	13	2	0	0	6,290
6260	NURSE AIDE TRAINING RE	0		0	0	0	0	6,295
6270	REHAB WAGES	76,184		10	1	0	0	6,390
6275	REHAB SICK & VAC	4,434		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	59,709	78,226	10	2	0	0	7,281
6295	NURSING SUPPLIES	8,880		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	9,637		10	2	0	0	7,391
6490	NURSING OTHER	191	4,971	10	3	0	0	7,393
7280	DRUG PURCHASES	112,351	260,787	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	148,134		39	2			7,540
7380	LABORATORY SERVICES	18,393	472,065	39	3	0	0	7,590
7410	HOME HEALTH SALARY			39	1	0	0	7,620
7440	HOME HEALTH SICK & VAC			39	1	0	0	7,660
7450	HOME HEALTH EXPENSES			39	3	0	0	7,710
7510	ACTIVITES WAGES	35,394	36,965	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	1,571		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	2,080	2,080	11	2	0	0	7,740
7595	ACTIVITIES FEES	0	0	11	3	0	0	7,750
7610	PT WAGES			39	1	0	0	7,770
7611	PT SICK & VACATION			39	1	0	0	7,820
7620	PT FEES	245,786		39	3	0	0 ***	7,890
7660	PT SUPPLIES	302		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	28,405	29,562	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	1,157		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	128	128	12	2	0	0	8,130
7740	OT FEE	147,497		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	60,389		39	3	0	0 ***	9,520
7800	BEAUTICIAN WAGES		0	40	1	0	0	9,530
7810	BEAUTICIAN SICK & VAC			40	1	0	0	
7820	BEAUTICIAN FEES	15,194	15,194	40	3	0	0	
7890	BEAUTY SHOP SUPPLIES	0	0	40	2	0	0	
7910	VOLUNTEER COORDINATOR			21	1	0	0	
7940	VOL COORD SICK & VAC			21	1	0	0	
7960	VOL COORD SUPPLIES	0		21	2	0	0	
8100	RENT	0	0	34	3	0	0	

8120	INTEREST EXPENSE	134,699	140,253	32	3	14	-978	
8130	DEPRECIATION	160,361	160,361	30	3	9	0	
8150	LOAN FEE AMORTIZATION	5,554		32	3	0	0	60,773
9510	INTEREST INCOME	-978		32	0	10	0	
9520	MISC NON-OPERATING INC	0		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	
		4,115,134	4,116,112					
			978					

GRAND TOTALS

-6,457

-38,065

(NET INCOME)

0

FACILITY NAME:

FACILITY ID:

0

FACILITY UNITS:

89

BALANCE SHEET TOTAL

0

	G/L	RECAP CENSUS
PP	6,867	6,867
IPA	14,454	14,454
medicare	2,817	2,817
		24,138
IPA BEDHOLDS	0	
PP BEDHOLDS	0	
PP CONVERS	0	

LES

3

FUND

ERIA

EBT

EBT

3,007 PATIENT

6,867

3,007 PATIENT	14,454
3,007 PATIENT	2,817
	0

3,010 BASIC CI	(3,664,554)
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3,020 BASIC CI	0
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3,030 BASIC CI	0
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	0
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3,080 NURSING	0
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3,081 NURSING	0
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3,082 NURSING	0
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3,083 NURSING	0
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3,100 DRUGS-M	(474,212)
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	0
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3,110 PHYSICA	(1,576,891)
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	0
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3,112 PHYSICA	0
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3,113 PHYSICA	0
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3,140 LABORATORY INCOME	
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	0
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3,152 ST/OT TF	0
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3,153 ST/OT TF	0
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3,185 REHAB/ISOLATION/OTHER CHG	
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3,410 IPA/OTH	0
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3,411 MEDICAL	0
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3,420 MEDICAL	1,547,143
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3,520 RENT IN	0
3,530 BEAUTY	(16,305)
	0
3,570 VENDING	0
3,590 EQUIPM	(14,750)
3,595 RESIDEN	(301)
3,600 MISC INC	0
4,110 G&A WA	143,072
4,111 ADMINIS	77,189
4,115 G&A PTC	10,788
4,120 EMPLOY	12,147
	0
4,130 EMPLOY	0
4,135 EMPLOY	(1,205)
4,250 OFFICE S	7,304
4,255 POSTAGI	996
4,260 TELEPHC	5,152
4,275 TRAININ	2,869
	0
4,280 GENERA	6,721
4,281 MEAL EX	54
4,285 EDUCAT	809
4,289 MEETING	0
4,290 HELP WA	2,977
4,291 PROMOT	8,735
4,292 PUBLIC I	3,150
4,300 LICENSE	45,449
4,310 DUES & F	4,737
4,320 CONTRIE	0
4,350 PROFESS	18,660
4,355 MEDICAL	16,500
	400
	4,380

4,364 SOCIAL S	5,039
4,370 TV RENT	(1,212)
4,383 BACKGR	2,066
4,390 OTHER T	0
4,400 PAYROL	169,482
4,401 PAYROL	8,012
4,410 GROUP I	148,930
4,420 LIABILIT	53,005
4,430 WORKM	35,648
4,435 W/C-FIRS	2,257
4,436 DRUG TE	0
4,450 MANAGI	206,641
4,460 BAD DEF	12,000
4,461 BAD DEF	78,279
4,470 LOST ITE	69
4,475 UNIFORM	1,706
4,486 SERVICE	15,666
4,490 MISC EX	0
4,496 MISC. M.	14,535
4,510 REAL ES	22,614
4,600 LEASED	9,862
5,110 MAINTEN	41,687
5,120 MAINTEN	937
5,130 ELECTRI	37,134
5,131 NATURA	12,030
5,133 WATER &	15,597
5,134 TRASH C	27,618
5,140 PROP/PL	3,815
5,160 GENERA	23,157
5,165 MAINTEN	16,744
5,210 DIETARY	166,215
5,220 DIETARY	5,232
5,248 FOOD PU	159,399

5,250 SUPPLIES	3,215
5,260 REPLACEMENTS	1,331
5,270 KITCHEN	7,093
5,295 MEAL IN	(933)
5,310 LAUNDRY	67,399
5,340 LAUNDRY	4,148
5,370 REPLACEMENTS	7,408
	0
5,390 SUPPLIES	6,198
5,410 HOUSEKEEPING	101,972
5,440 HOUSEKEEPING	3,806
5,480 SUPPLIES	166
5,490 SUPPLIES	32,265
6,020 RN WAGES	243,551
6,030 DONOR WAGES	60,318
6,035 ADONOR WAGES	0
6,040 RN PTO & OVERTIME	11,867
6,120 LPN WAGES	136,440
6,140 LPN PTO	5,106
6,220 AIDES WAGES	542,733
6,240 AIDES PTO	18,830
	0
	0
	0
	0
6,270 REHABILITATION	76,184
6,275 REHABILITATION	4,434
6,290 NURSING	59,709
6,295 NURSING	8,880
6,390 REPLACEMENTS	9,637
6,490 OTHER	191

7,280 DRUG PU	112,351
7,281 DRUG PU	148,134
7,380 LABORA	7,143
7,390 X-RAY S	11,250
	0
7,510 ACTIVIT	35,394
7,540 ACTIVIT	1,571
7,590 ACTIVIT	2,080
7,620 PHYSICA	245,786
7,660 P.T. SUP	302
7,710 SOCIAL S	28,405
7,720 SOCIAL S	1,157
7,730 SOCIAL S	128
7,740 OCCUPA	147,497
	0
7,770 SPEECH '	60,389
7,820 BEAUTIC	15,194
	0
	0
8,120 INTERES	134,699
	0
8,130 DEPRECI	160,361
	5,554
9,510 INTERES	(978)
9,520 MISC NO	0
4,220	0
8,100	0
9,702	0
5,230	0
	<u>(6,457)</u>

Expenses Fixed Assets

FACILITY	MEDICAID NUMBER	STATE LICENSE NUMBER
Owned SNFs		
Heritage Health - South, IL	20-5300302001	48843
Heritage Health - Bloomington, IL	20-3904134001	48157
Heritage Health - Carlinville, IL	20-5508113001	48850
Heritage Health - Chillicothe, IL	20-5412664001	48868
Heritage Health - Dwight, IL	20-5412784001	50492
Heritage Health - Elgin, IL	20-3902154001	48132
Heritage Health - El Paso, IL	20-3903447001	48124
Heritage Health - Gibson City, IL	20-3902572001	48116
Heritage Health - Gillespie, IL	20-5428620001	48892
Heritage Health - LaSalle, IL	27-3741988001	51276
Heritage Health - Litchfield, IL	20-5508096001	48900
Heritage Health - Mendota, IL	20-3904038001	48108
Heritage Health - Minonk, IL	20-3903980001	48058
Heritage Health - Mt. Sterling, IL	20-3903543001	48041
Heritage Health - Mt. Zion, IL	20-3903622001	48074
Heritage Health - Normal, IL	20-3903883001	48082
Heritage Health - Pana, IL	20-5508128001	48884
Heritage Health - Peru, IL	20-3902978001	48090
Heritage Health - Staunton, IL	20-5437628001	48876
Heritage Health - Streator, IL	20-3902216001	48066
Barton W. Stone Jackson, IL	20-5298969002	48918
Danville Joint Ventures, IL	37-1357323001	42168
Heritage Health - Springfield, IL	37-1359387001	41699
Cotillion Ridge, IL	37-1402726001	45138
Country Health - Springfield, IL	37-6064916001	7880
Mason City Area, IL	37-1168043001	34256
St. Clara's Medical Center, IL	37-6075710001	50724
Vonderlieth, IL	37-0967671001	19976