

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 0018002

Facility Name: The Tillers Nursing and Rehabilitation Center, Inc.

Address: 4390 Route 71 Oswego 60543
Number City Zip Code

County: Kendall

Telephone Number: (630) 554 - 1001 Fax # (630) 554-1668

HFS ID Number:

Date of Initial License for Current Owners: 08/01/72

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: Jeremy M. Brune, CPA Telephone Number: (779) 875 - 3979
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 01/01/11 to 12/31/11 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) Robert M. Saxon

(Title) Administrator

Paid Preparer

(Signed)

(Print Name and Title) Jeremy M. Brune, CPA

(Firm Name & Address) Jeremy Brune & Associates, LLC 2508 Riverwalk Drive Plainfield, Illinois 60586

(Telephone) (779) 875 - 3979 Fax # (866) 216 - 5355

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 **The Tillers Nursing and Rehabilitation Center, Inc.**

#	0018002	Report Period Beginning:	01/01/11	Ending:	12/31/11
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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

N/A

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	90	Skilled (SNF)	90	32,850		1	
2		Skilled Pediatric (SNF/PED)				2	
3	16	Intermediate (ICF)	16	5,840		3	
4		Intermediate/DD				4	
5		Sheltered Care (SC)				5	
6		ICF/DD 16 or Less				6	
7	106	TOTALS	106	38,690		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	394	13,344	18,236	31,974	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	394	13,344	18,236	31,974	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)	82.64%
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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)**

N/A

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 08/01/72

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 66 and days of care provided 15,690

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCUAL	☒	MODIFIED	☐	CASH*	☐
		CASH*	☐		

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

Tax Year: 12/31/11 **Fiscal Year:** 12/31/11

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

Facility Name & ID Number The Tillers Nursing and Rehabilitation Center # 0018002 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	420,325	28,117	12,837	461,279		461,279	2,130	463,409			1
2	Food Purchase		292,935		292,935		292,935	(21,526)	271,409			2
3	Housekeeping	256,837	31,203		288,040		288,040	294	288,334			3
4	Laundry		15,241		15,241		15,241		15,241			4
5	Heat and Other Utilities			120,183	120,183		120,183		120,183			5
6	Maintenance	139,056	63,774	164,284	367,114		367,114	9,469	376,583			6
7	Other (specify):*											7
8	TOTAL General Services	816,218	431,270	297,304	1,544,792		1,544,792	(9,633)	1,535,159			8
	B. Health Care and Programs											
9	Medical Director			44,400	44,400		44,400		44,400			9
10	Nursing and Medical Records	3,701,968	210,802	60,784	3,973,554		3,973,554	18,432	3,991,986			10
10a	Therapy	111,463	3,723		115,186		115,186		115,186			10a
11	Activities	79,094	17,171	2,172	98,437		98,437		98,437			11
12	Social Services	64,858		2,201	67,059		67,059		67,059			12
13	CNA Training											13
14	Program Transportation			37,580	37,580		37,580	(37,580)				14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,957,383	231,696	147,137	4,336,216		4,336,216	(19,148)	4,317,068			16
	C. General Administration											
17	Administrative	411,120			411,120		411,120	21,000	432,120			17
18	Directors Fees											18
19	Professional Services			102,860	102,860		102,860	(9,000)	93,860			19
20	Dues, Fees, Subscriptions & Promotions			93,459	93,459		93,459	(61,537)	31,922			20
21	Clerical & General Office Expenses	261,549	9,529	178,077	449,155		449,155	(70,199)	378,956			21
22	Employee Benefits & Payroll Taxes			982,885	982,885		982,885		982,885			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,100	11,100		11,100		11,100			24
25	Other Admin. Staff Transportation			1,987	1,987		1,987		1,987			25
26	Insurance-Prop.Liab.Malpractice			72,131	72,131		72,131		72,131			26
27	Other (specify):*											27
28	TOTAL General Administration	672,669	9,529	1,442,499	2,124,697		2,124,697	(119,736)	2,004,961			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,446,270	672,495	1,886,940	8,005,705		8,005,705	(148,517)	7,857,188			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			370,475	370,475		370,475	128,112	498,587			30
31	Amortization of Pre-Op. & Org.							862	862			31
32	Interest			101,990	101,990		101,990	101,458	203,448			32
33	Real Estate Taxes			113,099	113,099		113,099		113,099			33
34	Rent-Facility & Grounds			531,627	531,627		531,627	(531,627)				34
35	Rent-Equipment & Vehicles			20,386	20,386		20,386		20,386			35
36	Other (specify):*											36
37	TOTAL Ownership			1,137,577	1,137,577		1,137,577	(301,195)	836,382			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		843,700	1,870,568	2,714,268		2,714,268	(144,961)	2,569,307			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,860	109,860		109,860		109,860			42
43	Other (specify):*	90,591		30,560	121,151		121,151	(121,151)				43
44	TOTAL Special Cost Centers	90,591	843,700	2,010,988	2,945,279		2,945,279	(266,112)	2,679,167			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,536,861	1,516,195	5,035,505	12,088,561		12,088,561	(715,824)	11,372,737			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(21,526)	02		4
5	Telephone, TV & Radio in Resident Rooms	(13,667)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	82,518	30		9
10	Interest and Other Investment Income	(11,562)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(146)	32		18
19	Entertainment	(3,838)	21		19
20	Contributions	(900)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,353)	21		24
25	Fund Raising, Advertising and Promotional	(33,485)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(13,758)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(27,152)	20		28
29	Other-Attach Schedule	(191,130)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (242,999)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(472,825)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (472,825)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (715,824)		37

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

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

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

NON-ALLOWABLE EXPENSES		Sch. V Line	
	Amount	Reference	
1	Miscellaneous Income	\$ (580) 21	1
2	Medivan Income (To Extent of Expense)	(37,580) 14	2
3	Collection Expense	(7,277) 21	3
4	Website	(11,929) 21	4
5	Marketing Sales Call Expense	(17,469) 21	5
6	Marketing Salaries	(90,591) 43	6
7	Marketing Expenses	(32,098) 43	7
8	Capitalized Assets < \$2,500 - Dietary	2,130 01	8
9	Capitalized Assets < \$2,500 - Housekeeping	294 03	9
10	Capitalized Assets < \$2,500 - Maintenance	11,509 06	10
11	Capitalized Assets < \$2,500 - Marketing	1,538 43	11
12	Capitalized Assets < \$2,500 - Nursing	18,432 10	12
13	Capitalized Assets < \$2,500 - Office	6,672 21	13
14	Non-Allowable Legal Fees	(9,000) 19	14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23	Tillers Real Estate, LLC		23
24	Administration	(4,156) 17	24
25	Professional Fees	(9,412) 19	25
26	Office and Supplies	(387) 21	26
27	Bank Fees	(330) 21	27
28	Replacement Tax	(4,632) 21	28
29	Life Insurance	(6,264) 21	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	(191,130)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Tillers Nursing and Rehabilitation Center, Inc. # 0018002 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	2,130	0	0	0	0	0	0	0	0	0	0	2,130	1
2	Food Purchase	(21,526)	0	0	0	0	0	0	0	0	0	0	(21,526)	2
3	Housekeeping	294	0	0	0	0	0	0	0	0	0	0	294	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	11,509	0	0	(2,040)	0	0	0	0	0	0	0	9,469	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,593)	0	0	(2,040)	0	0	0	0	0	0	0	(9,633)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	18,432	0	0	0	0	0	0	0	0	0	0	18,432	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(37,580)	0	0	0	0	0	0	0	0	0	0	(37,580)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(19,148)	0	0	0	0	0	0	0	0	0	0	(19,148)	16
	C. General Administration													
17	Administrative	(4,156)	4,156	21,000	0	0	0	0	0	0	0	0	21,000	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(18,412)	9,412	0	0	0	0	0	0	0	0	0	(9,000)	19
20	Fees, Subscriptions & Promotions	(61,537)	0	0	0	0	0	0	0	0	0	0	(61,537)	20
21	Clerical & General Office Expenses	(81,812)	11,613	0	0	0	0	0	0	0	0	0	(70,199)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(165,917)	25,181	21,000	0	0	0	0	0	0	0	0	(119,736)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(192,658)	25,181	21,000	(2,040)	0	0	0	0	0	0	0	(148,517)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Tillers Nursing and Rehabilitation Center, Inc. # 0018002 Report Period Beginning: 01/01/11 Ending: 12/31/11

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
30	Depreciation	82,518	45,594	0	0	0	0	0	0	0	0	0	(to Sch V, col.7)
31	Amortization of Pre-Op. & Org.	0	862	0	0	0	0	0	0	0	0	0	128,112 30
32	Interest	(11,708)	113,166	0	0	0	0	0	0	0	0	0	862 31
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	101,458 32
34	Rent-Facility & Grounds	0	(531,627)	0	0	0	0	0	0	0	0	0	0 33
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	(531,627) 34
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 35
37	TOTAL Ownership	70,810	(372,005)	0	0	0	0	0	0	0	0	0	0 36
	Ancillary Expense												(301,195) 37
	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	(144,961)	0	0	0	0	0	0	0	0	(144,961) 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):*	(121,151)	0	0	0	0	0	0	0	0	0	0	(121,151) 43
44	TOTAL Special Cost Centers	(121,151)	0	(144,961)	0	0	0	0	0	0	0	0	(266,112) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(242,999)	(346,824)	(123,961)	(2,040)	0	0	0	0	0	0	0	(715,824) 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
Robert Saxon	33.34%			Tillers Real Estate	Oswego, Illinois	Building Co.
Sally Saxon	22.22%			Legacy Rehab	Oswego, Illinois	Therapy Co.
Karla Stone	22.22%			Legacy Rehab Plus	Oswego, Illinois	Cont. Therapy Co
Kathryn Rivero	22.22%					

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)	
1	V	34	Rental Income	\$ 531,627	Tillers Real Estate, LLC	100.00%	\$	\$ (531,627)	1
2	V	32	Interest Income	24	Tillers Real Estate, LLC	100.00%		(24)	2
3	V	17	Administration		Tillers Real Estate, LLC	100.00%	4,156	4,156	3
4	V	19	Professional Fees		Tillers Real Estate, LLC	100.00%	9,412	9,412	4
5	V	21	Office and Supplies		Tillers Real Estate, LLC	100.00%	387	387	5
6	V	21	Bank Fees		Tillers Real Estate, LLC	100.00%	330	330	6
7	V	21	Replacement Tax		Tillers Real Estate, LLC	100.00%	4,632	4,632	7
8	V	21	Life Insurance		Tillers Real Estate, LLC	100.00%	6,264	6,264	8
9	V	30	Depreciation		Tillers Real Estate, LLC	100.00%	45,594	45,594	9
10	V	31	Amortization		Tillers Real Estate, LLC	100.00%	862	862	10
11	V	32	Interest		Tillers Real Estate, LLC	100.00%	113,190	113,190	11
12	V								12
13	V								13
14	Total			\$ 531,651			\$ 184,827	\$ * (346,824)	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.

☒ X

 YES

☐ NO

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

1		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	17	Administration	\$	Legacy Rehab, LLC	100.00%	\$ 21,000	\$ 21,000	15
16	V	39	Therapy Services	1,758,405	Legacy Rehab, LLC	100.00%	1,613,444	(144,961)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								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			\$ 1,758,405			\$ 1,634,444	\$ * (123,961)	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	06	Rent	\$ 2,040	Legacy Rehab Plus, LLC	100.00%	\$	\$ (2,040)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								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			\$ 2,040			\$ 0	\$ * (2,040)	39

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

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	Robert Saxon	Owner	Administrator	33.34	0	40	100.00	Salary	\$ 213,892	17 - 01	1
2	Brett Saxon	Relative	Asst. Admin.	0.00	0	40	100.00	Salary	117,850	17 - 01	2
3								Rental Fee	4,800	21 - 03	3
4								Mgmt. Fee	21,000	39 - 07	4
5	Brooke Saxon-Spencer	Relative	Assoc. Admin.	0.00	0	30	100.00	Salary	79,378	17 - 01	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 436,920		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 The Tillers Nursing and Rehabilitation Center, Inc. # 0018002 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Tillers Real Estate, LLC
Street Address 4390 Route 71
City / State / Zip Code Oswego, Illinois 60543
Phone Number (630) 554 - 1001
Fax Number (630) 554 - 1668

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.

	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
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	TOTALS					\$	\$		\$	25

Facility Name & ID Number The Tillers Nursing and Rehabilitation Center, Inc. # 0018002 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Legacy Rehab, LLC
Street Address 4390 Route 71
City / State / Zip Code Oswego, Illinois 60543
Phone Number (630) 554 - 1001
Fax Number (630) 554 - 1668

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.

	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
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	TOTALS					\$	\$		\$	25

Facility Name & ID Number The Tillers Nursing and Rehabilitation Center, Inc. # 0018002 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Legacy Rehab Plus, LLC
Street Address 4390 Route 71
City / State / Zip Code Oswego, Illinois 60543
Phone Number (630) 554 - 1001
Fax Number (630) 554 - 1668

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.

	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
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	TOTALS					\$	\$		\$	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	Allied First Bank		X	Room Renovations	\$9,759.93		\$ 1,400,000	\$ 1,342,675		6.7500	\$ 101,844
2	Allied First Bank		X	Commercial Loan	\$2,959.57			114,683		6.7500	
3											
4	Allied First Bank - Tillers RE		X	Therapy Addition	\$11,821.26		1,600,000	1,523,089		7.3750	113,190
5											
	Working Capital										
6	Allied First Bank		X	Line of Credit						5.0000	
7											
8											
9	TOTAL Facility Related				\$24,540.76		\$ 3,000,000	\$ 2,980,447			\$ 215,034
	B. Non-Facility Related*										
10											
11											
12	Interest Income		X								(11,562)
13	Interest Income - Tillers RE		X								(24)
14	TOTAL Non-Facility Related						\$	\$			\$ (11,586)
15	TOTALS (line 9+line14)						\$ 3,000,000	\$ 2,980,447			\$ 203,448

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # N/A

* 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.)

HFS 3745 (N-4-99)

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 2010 report.		\$	78,196	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.)		\$	94,234	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	16,038	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	97,061	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.		\$	113,099	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	70,760	8	
		2007	73,564	9	
		2008	72,117	10	
		2009	75,918	11	
		2010	94,234	12	
Real Estate Tax Accrual = \$94,234 * 1.03% = \$97,061		13	FROM R. E. TAX STATEMENT FOR 2010	\$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Tillers Nursing and Rehabilitation Center, Inc. COUNTY Kendall

FACILITY IDPH LICENSE NUMBER 0018002

CONTACT PERSON REGARDING THIS REPORT Jeremy M. Brune

TELEPHONE (779) 875 - 3979 FAX #: (866) 216 - 5355

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.	03-20-202-004	Nursing Home	\$ 71,367.02	\$ 71,367.02
2.	03-17-456-002	Nursing Home	\$ 17,718.62	\$ 17,718.62
3.	03-14-456-001	Nursing Home	\$ 5,148.34	\$ 5,148.34
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 94,233.98	\$ 94,233.98

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 X 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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,500

B. General Construction Type: Exterior Brick Frame Steel 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).

N/A

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	Facility		1985	\$ 71,276	1
2	Tillers Real Estate			97,930	2
3	TOTALS			\$ 169,206	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	106		1972	1972	\$ 1,157,892	\$	35	\$		\$ 1,157,892	4
5			1981	1981	134,813		20			134,813	5
6			1985	1985	177,791		20			177,791	6
7			1986	1986	613,142		20			613,142	7
8			1987	1987	22,646		20			22,646	8
	Improvement Type**										
9	Various			1981	4,707		20			4,707	9
10	Various			1982	19,113		20			19,113	10
11	Various			1983	6,133		20			6,133	11
12	Various			1984	5,223		20			5,223	12
13	Various			1985	21,935		20			21,935	13
14	Various			1986	87,912		20			87,912	14
15	Various			1987	11,128		20			11,128	15
16	Various			1988	8,744		20			8,744	16
17	Various			1989	17,312		20			17,312	17
18	Various			1990	113,441		20			113,441	18
19	Various			1991	34,778		20	34,778	34,778	34,778	19
20	Various			1992	11,969		20	598	598	11,371	20
21	Various			1993	14,346		20	717	717	12,911	21
22	Various			1995	32,441		20	1,622	1,622	27,575	22
23	Various			1996	21,503		20	1,075	1,075	17,202	23
24	Various			1997	3,235		20	162	162	2,426	24
25	Various			1998	69,777		20	3,489	3,489	48,844	25
26	Various			1999	158,719		20	7,936	7,936	103,167	26
27	Various			2000	67,355		20	3,368	3,368	40,413	27
28	Various			2001	45,387		20	2,269	2,269	24,963	28
29	Various			2002	56,267		20	2,813	2,813	28,134	29
30	Various			2003	34,778		20	1,739	1,739	15,650	30
31	Various			2004	147,448		20	7,372	7,372	58,979	31
32	Various			2005	182,814		20	9,141	9,141	63,985	32
33	Various			2006	168,259		20	8,413	8,413	50,478	33
34	Various			2007	171,836		20	8,592	8,592	42,959	34
35											35
36											36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number The Tillers Nursing and Rehabilitation Center, Inc.

0018002

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Gait Door and Lock	2008	\$ 2,445	\$	20	\$ 122	\$ 122	\$ 489	37
38 Gait Lock	2008	1,285		20	64	64	257	38
39 Roofing	2008	34,980		20	1,749	1,749	6,996	39
40 Flooring	2008	7,000		20	350	350	1,400	40
41 Alarm System	2008	4,080		20	204	204	816	41
42 Therapy Gym Construction Addition	2008	1,452,534		20	72,627	72,627	290,507	42
43 Landscaping	2008	35,827		20	1,791	1,791	7,165	43
44 Therapy Gym Construction Addition - Final Costs	2009	42,856		20	2,143	2,143	6,428	44
45 Annunciator Panel Rewire	2009	4,500		20	225	225	675	45
46 Annunciator Panel	2009	2,036		20	102	102	305	46
47 Entry Sign Design	2009	1,980		20	99	99	297	47
48 500 Wing - Architect / Construction / Permits	2009	156,982		20	7,849	7,849	23,547	48
49 Resident Room Renewal - Flooring / Electrical / Wiring / Etc	2009	1,325,144		20	66,257	66,257	198,772	49
50 Qmark 7.5 KW Heater	2009	1,800		20	90	90	270	50
51 Smoke Detectors	2009	500		20	25	25	75	51
52 Smoke Detectors	2009	500		20	25	25	75	52
53 Parking Lot	2010	108,737		20	5,437	5,437	10,874	53
54 Roofing	2010	36,120		20	1,806	1,806	3,612	54
55 Resident Room Renewal - Flooring / Electrical / Wiring / Etc	2010	88,440		20	4,422	4,422	8,844	55
56 Electric Install	2010	2,900		20	145	145	290	56
57 Door Frame, Door, and Hinges	2010	2,235		20	112	112	224	57
58 Therapy Gym Gutters	2010	1,140		20	57	57	114	58
59 Signs	2011	3,830		20	192	192	192	59
60 Air Conditioner	2011	21,050		20	1,052	1,052	1,052	60
61 Parking Lot Asphalt	2011	40,814		20	2,041	2,041	2,041	61
62 Dishwasher Construction	2011	17,239		20	862	862	862	62
63 Light Pole	2011	7,447		20	372	372	372	63
64								64
65								65
66 Depreciation - Tillers Nursing and Rehabilitaton Center, Inc.			370,475			(370,475)		66
67 Depreciation - Tillers Real Estate, LLC			45,594			(45,594)		67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 7,027,245	\$ 416,069		\$ 264,305	\$ (151,764)	\$ 3,552,318	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,291,458	\$	\$ 229,146	\$ 229,146	10	\$ 1,963,082	71
72	Current Year Purchases	57,597		5,137	5,137	10	5,137	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,349,055	\$	\$ 234,282	\$ 234,282		\$ 1,968,218	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	Facility	Dodge Van	1989	\$ 18,762	\$	\$	\$	5	\$ 18,762	76
77	Facility	Dodge Truck	1998	20,000				5	20,000	77
78	Facility	Chevy Silverado	2006	22,500				5	22,500	78
79										79
80	TOTALS			\$ 61,262	\$	\$	\$		\$ 61,262	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 9,606,768	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 416,069	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 498,587	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 82,518	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,581,798	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	Automobile - 1985	\$ 19,557	\$	\$ 19,557	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 19,557	\$	\$ 19,557	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: N/A
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: \$ 20,386
- Description:
- Copiers

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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. /2012 \$
13. /2013 \$
14. /2014 \$

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 764,218	\$		\$ 764,218	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			98,058			98,058	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			897,815			897,815	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				798,437		798,437	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					45,263		45,263	12
13	Other (specify): See Supplemental	39 - 03				110,477			110,477	13
14	TOTAL			\$		\$ 1,870,568	\$ 843,700		\$ 2,714,268	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 48,445	\$ 74,793	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,248,672	2,248,672	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	29,750	29,750	5
6	Prepaid Insurance	94,510	94,510	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental	4,803	4,803	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,426,180	\$ 2,452,528	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	71,276	169,206	13
14	Buildings, at Historical Cost	1,020,122	3,497,849	14
15	Leasehold Improvements, at Historical Cost	2,996,020	3,031,847	15
16	Equipment, at Historical Cost	2,514,835	2,581,752	16
17	Accumulated Depreciation (book methods)	(4,322,819)	(5,501,846)	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): See Supplemental	85,211	103,988	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,364,645	\$ 3,882,796	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,790,825	\$ 6,335,324	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 409,539	\$ 409,539	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	421,289	421,289	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,464	34,529	31
32	Accrued Real Estate Taxes(Sch.IX-B)	97,061	97,061	32
33	Accrued Interest Payable	8,198	8,198	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental	52,970		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,016,521	\$ 970,616	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,457,358	2,980,447	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,457,358	\$ 2,980,447	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,473,879	\$ 3,951,063	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,316,946	\$ 2,384,261	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,790,825	\$ 6,335,324	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,267,134	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,267,134	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	625,287	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	(575,475)	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)	\$ 49,812	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)	\$ 2,316,946	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Tillers Nursing and Rehabilitation Center, Inc. # 0018002 Report Period Beginning: 01/01/11Ending: 12/31/11**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	\$ 12,475,661	1
2	Discounts and Allowances for all Levels	(3,766,953)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,708,708	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,552,633	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,552,633	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	5,843	13
14	Non-Patient Meals	21,526	14
15	Telephone, Television and Radio	13,667	15
16	Rental of Facility Space	2,040	16
17	Sale of Drugs	805,060	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	140,828	19
20	Radiology and X-Ray	45,981	20
21	Other Medical Services	335,028	21
22	Laundry	22,273	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,392,246	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,562	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,562	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	48,699	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 48,699	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,713,848	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,544,792	31
32	Health Care	4,336,216	32
33	General Administration	2,124,697	33
	B. Capital Expense		
34	Ownership	1,137,577	34
	C. Ancillary Expense		
35	Special Cost Centers	2,835,419	35
36	Provider Participation Fee	109,860	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,088,561	40
41	Income before Income Taxes (line 30 minus line 40)**	625,287	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 625,287	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No 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	2,000	2,080	\$ 92,243	\$ 44.35	1
2	Assistant Director of Nursing	2,403	2,648	86,107	32.52	2
3	Registered Nurses	58,312	60,756	1,718,391	28.28	3
4	Licensed Practical Nurses	11,455	13,349	297,893	22.32	4
5	CNAs & Orderlies	112,105	120,633	1,453,818	12.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,954	5,335	111,463	20.89	8
9	Activity Director	2,000	2,080	29,085	13.98	9
10	Activity Assistants	4,566	5,025	50,010	9.95	10
11	Social Service Workers	4,090	4,265	64,858	15.21	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	41,544	19.97	13
14	Head Cook					14
15	Cook Helpers/Assistants	39,642	42,288	378,781	8.96	15
16	Dishwashers					16
17	Maintenance Workers	8,633	9,087	139,056	15.30	17
18	Housekeepers	22,950	24,862	256,837	10.33	18
19	Laundry					19
20	Administrator	2,000	2,080	213,892	102.83	20
21	Assistant Administrator	3,480	3,640	197,228	54.18	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,971	14,347	261,549	18.23	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	2,000	2,080	53,515	25.73	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Supplemental</u>	2,720	2,737	90,591	33.10	33
34	TOTAL (lines 1 - 33)	299,281	319,372	\$ 5,536,861 *	\$ 17.34	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		\$ 12,837	01 - 03	35
36	Medical Director		44,400	09 - 03	36
37	Medical Records Consultant		1,813	10 - 03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,009	10 - 03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		2,172	11 - 03	44
45	Social Service Consultant		2,201	12 - 03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 67,432		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 19,710	10 - 03	50
51	Licensed Practical Nurses		1,514	10 - 03	51
52	Certified Nurse Assistants/Aides		3,513	10 - 03	52
53	TOTAL (lines 50 - 52)		\$ 24,737		53

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Page 20 Supplemental Schedule

Description	Hours Worked	Hours Paid	Salary
Other Salaries			
Marketing	2,720	2,737	90,591
Total	2,720	2,737	90,591

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
Robert Saxon	Administrator	33.34	\$ 213,892	Workers' Compensation Insurance	\$	102,821	IDPH License Fee	\$
Brett Saxon	Asst. Admin.	0	117,850	Unemployment Compensation Insurance		70,680	Advertising: Employee Recruitment	6,085
Brooke Saxon - Spencer	Assc. Admin	0	79,378	FICA Taxes		412,582	Health Care Worker Background Check	
				Employee Health Insurance		312,087	(Indicate # of checks performed)	7,730
				Employee Meals			Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues	8,407
				Physicals		9,310	Subscriptions and Licenses	9,700
				Pension		22,415	Advertising and Promotions	60,637
				Employee Recognition		1,780		
				Life and Disability Insurance		11,962		
				Other Employee Benefits		21,068	Less: Public Relations Expense (	
				Accrued PTO Adjustment & Payroll Taxes		18,180	Non-allowable advertising	(33,485)
							Yellow page advertising	(27,152)
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 411,120	TOTAL (agree to Schedule V,	\$	982,885	TOTAL (agree to Sch. V,	\$ 31,922
(List each licensed administrator separately.)				line 22, col.8)			line 20, col. 8)	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
DB Solutions, LLC	IT Support		\$ 9,349					
ADP	Payroll Processing		7,993					
Paylocity	Payroll Processing		12,886					
Jeremy Brune & Associates	Accounting		13,503					
IVANS	Data Processing		1,014					
FR&R	Billing Consulting		1,255					
Culture Index, Inc.	Culture Study		23,100					
Dommermuth, Brestal, C	Legal		1,250					
Duane Morris, LLP	Legal		18,156					
Law Offices of James P. Write	Legal		3,290					
Thompson Coburn, LLP	Legal		2,866					
See Supplemental Schedule	See Supplemental Schedule		8,199					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 102,860	TOTAL		\$	Entertainment Expense (	
(If total legal fees exceed \$5,000, attach copy of invoices.)							(agree to Sch. V,	
							line 24, col. 8)	\$ 11,100

* Attach copy of IMRF notifications

**See instructions.

The Tillers Nursing and Rehabilitation Center, Inc.
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Page 21 Supplemental Schedule - Other Professional Fees

Vendor	Type	Amount
Wessels Sherman	Legal	650
Legal Adjustment	Legal	(805)
Accu-Med Services	Data Processing	4,380
Nebo Systems	Data Processing	240
Dufek & Company, LLC	Profit Sharing Audit	3,734
Total		8,199

The Tillers Nursing and Rehabilitation Center, Inc.
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Page 21 Supplemental Schedule - Legal Schedule

Vendor	Posting Date	Amount	Allowable
Dommermuth, Brestal, C	04/30/11	850	-
Dommermuth, Brestal, C	05/31/11	400	-
		1,250	-
Duane Morris, LLP	01/26/11	1,879	
Duane Morris, LLP	01/26/11	440	
Duane Morris, LLP	01/31/11	743	743
Duane Morris, LLP	01/31/11	230	230
Duane Morris, LLP	03/31/11	403	403
Duane Morris, LLP	06/22/11	115	115
Duane Morris, LLP	06/30/11	2,019	2,019
Duane Morris, LLP	09/30/11	345	345
Duane Morris, LLP	09/30/11	6,519	6,519
Duane Morris, LLP	10/26/11	970	970
Duane Morris, LLP	10/31/11	115	115
Duane Morris, LLP	10/31/11	115	115
Duane Morris, LLP	10/31/11	230	230
Duane Morris, LLP	10/31/11	929	929
Duane Morris, LLP	11/30/11	1,265	1,265
Duane Morris, LLP	11/30/11	1,725	1,725
Duane Morris, LLP	12/31/11	115	115
		18,156	15,837
Law Offices of James P. Write	02/28/11	820	-
Law Offices of James P. Write	04/27/11	200	-
Law Offices of James P. Write	06/22/11	1,130	-
Law Offices of James P. Write	07/27/11	120	-
Law Offices of James P. Write	08/31/11	200	-
Law Offices of James P. Write	10/26/11	300	-
Law Offices of James P. Write	11/30/11	60	-
Law Offices of James P. Write	12/31/11	460	-
		3,290	-
Thompson Coburn, LLP	01/26/11	177	
Thompson Coburn, LLP	01/31/11	532	532
Thompson Coburn, LLP	04/30/11	166	-

The Tillers Nursing and Rehabilitation Center, Inc.
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Page 21 Supplemental Schedule - Seminar Schedule

Vendor	Type	Amount
UpStairs Solutions	On-Line Training Program	8,651
FR&R	Medicare Update	2,500
Pathway Services	Webinar	299
Nursing Scholarships		(350)
Total		11,100

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	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
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?
If YES, give association name and amount.

Yes
IHCA - \$8,408
- (3) Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

Yes
Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A
- (5) Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$30,708
Line10 - 02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes
- (8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
N/A
- (9) Are you presently operating under a sublease agreement?

YESXNO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YESNO
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

X
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$109,860
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

Yes
- (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?

N/A
- (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?
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.

No
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$0
Yes
Indicate the amount. \$21,526
- (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?
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

No
N/A
Ln 14
Yes
No
Yes

g. Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$N/A
- (17) Has an audit been performed by an independent certified public accounting firm?
Firm Name:

No
N/A
- (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?
Attach invoices and a summary of services for all architect and appraisal fees

Yes