

Facility Name & ID Number The Clayberg

0014290 Report Period Beginning: 12/1/08 Ending: 11/30/09

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 49

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,885	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	49	TOTALS	49	17,885	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	
8	SNF				8
9	SNF/PED				9
10	ICF	11,831	2,740		14,571
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	11,831	2,740		14,571

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.47%

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

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

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

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

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 7/6/69

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 _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 11/30/09 Fiscal Year: 11/30/09

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

Facility Name & ID Number The Clayberg # 0014290 Report Period Beginning: 12/1/08 Ending: 11/30/09

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	204,621	7,933	4,520	217,074		217,074		217,074		1
2	Food Purchase		92,708		92,708		92,708	(6,181)	86,527		2
3	Housekeeping	151,584	10,561		162,145		162,145		162,145		3
4	Laundry		7,187		7,187		7,187		7,187		4
5	Heat and Other Utilities			81,372	81,372		81,372	(2,050)	79,322		5
6	Maintenance	61,722	7,737	24,366	93,825		93,825		93,825		6
7	Other (specify):*										7
8	TOTAL General Services	417,927	126,126	110,258	654,311		654,311	(8,231)	646,080		8
B. Health Care and Programs											
9	Medical Director										9
10	Nursing and Medical Records	933,859	53,668	3,983	991,510		991,510		991,510		10
10a	Therapy	49,793		5,807	55,600		55,600		55,600		10a
11	Activities	70,766	2,980	500	74,246		74,246		74,246		11
12	Social Services	34,885		500	35,385		35,385		35,385		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,089,303	56,648	10,790	1,156,741		1,156,741		1,156,741		16
C. General Administration											
17	Administrative	55,372		2,266	57,638		57,638		57,638		17
18	Directors Fees										18
19	Professional Services			4,798	4,798		4,798		4,798		19
20	Dues, Fees, Subscriptions & Promotions			6,423	6,423		6,423	(2,926)	3,497		20
21	Clerical & General Office Expenses	37,613	4,330	2,879	44,822		44,822	5,660	50,482		21
22	Employee Benefits & Payroll Taxes			539,507	539,507		539,507		539,507		22
23	Inservice Training & Education										23
24	Travel and Seminar			582	582		582		582		24
25	Other Admin. Staff Transportation			755	755		755		755		25
26	Insurance-Prop.Liab.Malpractice			35,386	35,386		35,386		35,386		26
27	Other (specify):* County Assessment			577,538	577,538		577,538	(577,538)			27
28	TOTAL General Administration	92,985	4,330	1,170,134	1,267,449		1,267,449	(574,804)	692,645		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,600,215	187,104	1,291,182	3,078,501		3,078,501	(583,035)	2,495,466		29

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

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

Facility Name & ID Number

The Clayberg

#0014290

Report Period Beginning:

12/1/08

Ending:

11/30/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
30	D. Ownership Depreciation			43,469	43,469	43,469		43,469			30	
31	Amortization of Pre-Op. & Org.										31	
32	Interest										32	
33	Real Estate Taxes										33	
34	Rent-Facility & Grounds										34	
35	Rent-Equipment & Vehicles			1,758	1,758	1,758		1,758			35	
36	Other (specify):* Loss on disposal of assets			413	413	413		413			36	
37	TOTAL Ownership			45,640	45,640	45,640		45,640			37	
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportator										38	
39	Ancillary Service Centers		3,506	1,153	4,659	4,659		4,659			39	
40	Barber and Beauty Shops										40	
41	Coffee and Gift Shops		1,194		1,194	1,194	(169)	1,025			41	
42	Provider Participation Fee			26,830	26,830	26,830		26,830			42	
43	Other (specify):*										43	
44	TOTAL Special Cost Centers		4,700	27,983	32,683	32,683	(169)	32,514			44	
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,600,215	191,804	1,364,805	3,156,824	3,156,824	(583,204)	2,573,620			45	

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

Facility Name & ID Number The Clayberg

0014290

Report Period Beginning:

12/1/08

Ending:

11/30/09

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,181)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,050)	5		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				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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,926)	20		25
	Income Taxes and Illinois Persona				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(577,707)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (588,864)		\$	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
	Amortization of Organization & Pre-Operating Expense			
33				33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	5,660	SchVII	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 5,660		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (583,204)		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		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

The Clayberg

Report Period Beginning: 12/1/08
 Ending: 11/30/09

ID# 0014290

Sch. V Line
Reference

NON-ALLOWABLE EXPENSES

Amount

1	Vending Maching Costs	\$ (169)	41
2	County Contribution to State	(577,538)	27
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			
31			
32			
33			
34			
35			
36			
37			
38			
39			
40			
41			
42			
43			
44			
45			
46			
47			
48			
49	Total	(577,707)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Clayberg# 0014290 Report Period Beginning:

12/1/08

Ending:

11/30/09

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,181)	0	0	0	0	0	0	0	0	0	0	(6,181)	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	(2,050)	0	0	0	0	0	0	0	0	0	0	(2,050)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(8,231)	0	0	0	0	0	0	0	0	0	0	(8,231)	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	0	0	0	0	0	0	0	0	0	0	0	0	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	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	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,926)	0	0	0	0	0	0	0	0	0	0	(2,926)	20
21	Clerical & General Office Expenses	0	5,660	0	0	0	0	0	0	0	0	0	5,660	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):*	(577,538)	0	0	0	0	0	0	0	0	0	0	(577,538)	27
28	TOTAL General Administration	(580,464)	5,660	0	(574,804)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(588,695)	5,660	0	(583,035)	29								

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Fulton County	100	None		Fulton County	Lewistown	County Gov't

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	21 Payroll	\$	Fulton County	100.00%	\$ 5,660	\$ 5,660	1
2	V	22 Health Insurance	103,427	Fulton County	100.00%	103,427		2
3	V	22 IMRF	120,510	Fulton County	100.00%	120,510		3
4	V	22 FICA	122,416	Fulton County	100.00%	122,416		4
5	V	22 Workers' Comp Insurance	62,046	Fulton County	100.00%	62,046		5
6	V	22 Unemployment Insurance	18,578	Fulton County	100.00%	18,578		6
7	V	17 Committee Per Diem Expense	2,266	Fulton County	100.00%	2,266		7
8	V	26 Property & Liability Insurance	35,286	Fulton County	100.00%	35,286		8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 464,529			\$ 470,189	\$ * 5,660	14

* 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	None								\$	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 The Clayberg

0014290 Report Period Beginning: 12/1/08

Ending: 11/30/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	None						\$	\$				\$						
2																		
3																		
4																		
5																		
Working Capital																		
6	None																	
7																		
8																		
9	TOTAL Facility Related						\$	\$				\$						
B. Non-Facility Related*																		
10	None																	
11																		
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$				\$						
15	TOTALS (line 9+line14)						\$	\$				\$						

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.)

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,920 B. General Construction Type: Exterior Brick Frame Concrete & Steel Number of Stories one

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).
none

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Building Site</u>	<u>217,800</u>	<u>1969</u>	<u>\$ 5,000</u>	1
2					2
3	TOTALS	217,800		\$ 5,000	3

Facility Name & ID Number The Clayberg

0014290

Report Period Beginning:

12/1/08

Ending:

11/30/09

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	49		1969		\$ 271,336	\$ 6,432	40	\$ 6,432		\$ 271,336	4
5			1978		8,009		20			8,009	5
6			1979		52,592		30			52,592	6
7											7
8											8
		Improvement Type**									
9		windows and plaster repair	1981		17,092		3 to 10			17,092	9
10		front porch and patio	1982		6,110		5 to 20			6,110	10
11		office remodeling	1983		3,272		5 to 10			3,272	11
12		roof	1984		2,005		10			2,005	12
13		canvas, floors, sewer, box, sign, door	1985		17,304	322	15 to 25	322		17,183	13
14		shutters	1986		1,591	16	15 to 25	16		1,574	14
15		shed, roof and flor tile	1987		17,275	50	15 to 25	50		17,139	15
16		heating and cooling system	1988		9,166		20			9,166	16
17		IDPA adjustment	1989		1,806	90	20	90		1,174	17
18		new shed	1990		8,284		15			8,284	18
19		new shed	1991		10,876		15			10,876	19
20		drain	1992		743		15			743	20
21		roof and greenhouse	1993		62,282		15			62,282	21
22		road repair	1994		13,496		5			13,496	22
23		storage building addition	1994		4,265	213	20	213		3,003	23
24		storage building addition	1996		12,141	607	20	607		8,280	24
25		laundry facility	1997		15,274	764	20	764		9,641	25
26		carpet, H/C system	2000		6,298	402	10 to 20	402		3,797	26
27		walk path	2001		4,177	278	15	278		2,274	27
28		walk path	2002		1,357	90	15	90		671	28
29		aviary	2002		4,740	316	15	316		2,344	29
30		flooring	2004		635	64	10	64		365	30
31		two A/C units	2004		4,583	458	10	458		2,445	31
32		floor tile	2005		289	12	25	12		56	32
33		electrical box	2005		141	6	25	6		27	33
34		seal parking lot	2005		1,260	79	4	79		1,260	34
35		two metal doors	2005		1,166	39	30	39		185	35
36		wall coverings	2005		697	139	5	139		662	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 Clayberg

0014290

Report Period Beginning:

12/1/08

Ending:

11/30/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	egress lights	2005	\$ 423	\$ 28	15	\$ 28	\$	\$ 134	37
38	smoke detectors	2005	2,915	291	10	291		1,385	38
39	new corridor wall	2005	367	15	25	15		70	39
40	paint walls	2005	112		3			112	40
41	kitchen fire system	2005	2,877	82	35	82		377	41
42	sidewalk	2005	802	53	15	53		241	42
43	labor for bldg improvements	2005	5,904	393	15	393		1,771	43
44	heating and cooling units	2005	2,729	273	10	273		1,160	44
45	harbor in garden	2005	868	35	25	35		145	45
46	base board heaters	2006	278	19	15	19		73	46
47	wall board and glue	2006	168	34	5	34		129	47
48	floor tile	2006	640	26	25	26		96	48
49	East egress	2006	1,701	113	15	113		406	49
50	East egress soil	2006	390	13	30	13		47	50
51	door and frame	2006	614	20	30	20		73	51
52	water main	2006	9,291	232	40	232		774	52
53	water main walkway	2006	1,031	69	15	69		229	53
54	door locks	2006	474	31	15	31		100	54
55	labor for bldg improvements	2006	4,098	273	15	273		956	55
56	steel door	2007	630	21	30	21		54	56
57	sprinkler system/ceiling upgrade	2007	151,553	10,104	15	10,104		23,575	57
58	wiring/electrical outlets	2007	635	32	20	32		71	58
59	4 A/C units	2007	1,668	167	10	167		375	59
60	Sentricon Baiting system	2008	1,272	85	15	85		170	60
61	packaged unit and duct work	2008	6,105	407	15	407		441	61
62	Roof work	2008	28,174	1,878	15	1,878		1,878	62
63	generator repair	2009	2,170	24	15	24		24	63
64	Fire Protection - Sprinkler system	2009	25,825		15				64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 813,976	\$ 25,095		\$ 25,095	\$	\$ 572,209	70

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

Facility Name & ID Number The Clayberg

0014290

Report Period Beginning:

12/1/08

Ending:

11/30/09

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 175,037	\$ 15,843	\$ 15,843	\$	5 to 20	\$ 98,591	71
72	Current Year Purchases	18,645	1,254	1,254		5 to 10	1,254	72
73	Fully Depreciated Assets	199,846	1,277	1,277		5 to 20	199,846	73
74								74
75	TOTALS	\$ 393,528	\$ 18,374	\$ 18,374	\$		\$ 299,691	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	patient transportation	2000 Chevy Bus	2000	\$ 42,641	\$	\$	\$	5	\$ 42,641	76
77	pickup, delivery & plowing	2001 Ford Truck with plow	2001	23,817				5	23,817	77
78										78
79										79
80	TOTALS			\$ 66,458	\$	\$	\$		\$ 66,458	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,278,962	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 43,469	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 43,469	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 938,358	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number The Clayberg

0014290

Report Period Beginning: 12/1/08

Ending: 11/30/09

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: \$ 1,758 Description: copier 146.48/month

(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. /2010 \$ _____

13. /2011 \$ _____

14. /2012 \$ _____

* 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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>No nurses aides were trained during this report period because the facility hired only aides who were already certified.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	--

B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility			
	1	2	3	4
	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	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$				1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		6	172		6	172	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		36	5,635		36	5,635	4
5	Physician Care		visits							5
6	Dental Care	39-3	visits			1,153			1,153	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>Stock Drugs</u>	39-2					3,506		3,506	13
14	TOTAL			\$	42	\$ 6,960	\$ 3,506	42	\$ 10,466	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number The Clayberg

0014290

Report Period Beginning: 12/1/08

Ending:

11/30/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/09

(last day of reporting year)

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	\$ 558,719	\$ 1
2	Cash-Patient Deposits	21,977	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	104,127	3
4	Supply Inventory (priced at <u>Cost</u>)	3,076	4
5	Short-Term Investments	205,873	5
6	Prepaid Insurance		6
7	Other Prepaid Expenses		7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify): <u>Property Tax Rec.</u>	381,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,274,772	\$ 10
B. Long-Term Assets			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land	5,000	13
14	Buildings, at Historical Cost	813,976	14
15	Leasehold Improvements, at Historical Cos		15
16	Equipment, at Historical Cost	459,986	16
17	Accumulated Depreciation (book methods)	(938,358)	17
18	Deferred Charges		18
19	Organization & Pre-Operating Costs		19
20	Accumulated Amortization - Organization & Pre-Operating Costs		20
21	Restricted Funds		21
22	Other Long-Term Assets (specify):		22
23	Other(specify):		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 340,604	\$ 24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,615,376	\$ 25

	1	2	
	Operating	After	
		Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 29,679	\$ 26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits	21,977	28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	46,242	30
31	Accrued Taxes Payable (excluding real estate taxes)		31
32	Accrued Real Estate Taxes(Sch.IX-B)		32
33	Accrued Interest Payable		33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
Other Current Liabilities(specify):			
36	<u>County Assessment and def. prop. Tax</u>	383,683	36
37	<u>Due to Cty GF and accr. Comp abs</u>	264,431	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 746,012	\$ 38
D. Long-Term Liabilities			
39	Long-Term Notes Payable	60,131	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)	\$ 60,131	\$ 45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 806,143	\$ 46
47	TOTAL EQUITY (page 18, line 24)	\$ 809,233	\$ 47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,615,376	\$ 48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 798,383	1
2	Restatements (describe):		2
3	Prior period rate adjustment to reduce revenue		3
4	and record a due to state	(62,500)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 735,883	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(391,179)	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)	\$ (391,179)	17
	B. Transfers (Itemize):		
18	Transfer in from County IMRF Fund	120,510	18
19	Transfer in from County FICA Fund	122,416	19
20	Transfer in from County General Fund	105,693	20
21	Transfer in from County Insurance fund	97,332	21
22	Transfer in from County Unemployment fund	18,578	22
23	TOTAL Transfers (sum of lines 18-22)	\$ 464,529	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 809,233	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Clayberg# 0014290Report Period Beginning: 12/1/08Ending: 11/30/09**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	\$ 2,372,738	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,372,738	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	169	12
13	Barber and Beauty Care	320	13
14	Non-Patient Meals	6,181	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 6,670	23
D. Non-Operating Revenue			
24	Contributions	3,973	24
25	Interest and Other Investment Income***	15,340	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 19,313	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Property Taxes</u>	366,924	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 366,924	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,765,645	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	654,311	31
32	Health Care	1,156,741	32
33	General Administration	1,267,449	33
B. Capital Expense			
34	Ownership	45,640	34
C. Ancillary Expense			
35	Special Cost Centers	5,853	35
36	Provider Participation Fee	26,830	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,156,824	40
41	Income before Income Taxes (line 30 minus line 40)**	(391,179)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (391,179)	43

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

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

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

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

Facility Name & ID Number The Clayberg

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	2,080	2,080	\$ 64,754	\$ 31.13	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,016	5,347	130,379	24.38	3
4	Licensed Practical Nurses	11,115	12,248	237,470	19.39	4
5	CNAs & Orderlies	39,548	42,706	458,036	10.73	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,225	3,744	49,793	13.30	8
9	Activity Director	1,858	2,057	27,571	13.40	9
10	Activity Assistants	3,671	3,896	43,195	11.09	10
11	Social Service Workers	1,900	2,199	34,885	15.86	11
12	Dietician					12
13	Food Service Supervisor	1,849	2,034	42,502	20.90	13
14	Head Cook	10,169	11,156	125,454	11.25	14
15	Cook Helpers/Assistants	3,497	3,776	36,665	9.71	15
16	Dishwashers					16
17	Maintenance Workers	3,345	3,991	61,722	15.47	17
18	Housekeepers	14,427	15,869	151,584	9.55	18
19	Laundry					19
20	Administrator	2,080	2,080	55,372	26.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,330	1,991	37,613	18.89	23
24	Clerical					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 Plan Coord	1,486	1,904	43,220	22.70	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	106,596	117,078	\$ 1,600,215 *	\$ 13.67	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	98	\$ 4,520	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,240	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	500	11-3	44
45	Social Service Consultant	12	500	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	122	\$ 8,760		49

C. CONTRACT NURSES

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

Facility Name & ID Number The Clayberg

0014290

Report Period Beginning: 12/1/08

Ending: 11/30/09

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? yes
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. CNHA 400, INHA 100
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (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? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,026 Line 10
- (7) Have all costs reported on this form been determined using accounting procedure consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES 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. \$ 26,830
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? No 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 benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 6,181
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
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? N/A
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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Clifton Gunderson, LLP
- (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 service performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees