

Facility Name & ID Number Seminary Manor

0047233 Report Period Beginning: 10/1/08 Ending: 9/30/09

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 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	121	Skilled (SNF)	121	44,165	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	121	TOTALS	121	44,165	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	13,739	15,189	8,803	37,731	8
9	SNF/PED					9
10	ICF		0			10
11	ICF/DD					11
12	SC		0			12
13	DD 16 OR LESS					13
14	TOTALS	13,739	15,189	8,803	37,731	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.43%

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 08/01/05

J. Was the facility purchased or leased after January 1, 1978?
YES Date 07/28/05 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 121 and days of care provided 8,803

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

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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	287,555	69,667	10,645	367,867		367,867		367,867		1
2	Food Purchase		353,885		353,885		353,885		353,885		2
3	Housekeeping	110,697	47,657		158,354		158,354		158,354		3
4	Laundry	50,804	26,750		77,554		77,554		77,554		4
5	Heat and Other Utilities			166,103	166,103		166,103		166,103		5
6	Maintenance	61,249	61,686	86,675	209,610		209,610		209,610		6
7	Other (specify):*										7
8	TOTAL General Services	510,305	559,645	263,423	1,333,373		1,333,373		1,333,373		8
	B. Health Care and Programs										
9	Medical Director			33,595	33,595		33,595		33,595		9
10	Nursing and Medical Records	1,815,127	535,875	3,120	2,354,122		2,354,122		2,354,122		10
10a	Therapy	11,211		582,022	593,233		593,233		593,233		10a
11	Activities	80,102	5,247		85,349		85,349		85,349		11
12	Social Services	34,336			34,336		34,336		34,336		12
13	CNA Training			120	120		120		120		13
14	Program Transportation			230	230	2,858	3,088		3,088		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,940,776	541,122	619,087	3,100,985	2,858	3,103,843		3,103,843		16
	C. General Administration										
17	Administrative	162,147			162,147		162,147		162,147		17
18	Directors Fees							3,048	3,048		18
19	Professional Services			338,425	338,425		338,425	(1,358)	337,067		19
20	Dues, Fees, Subscriptions & Promotions			101,552	101,552		101,552	(78,664)	22,888		20
21	Clerical & General Office Expenses	69,640	38,034	40,102	147,776		147,776	38	147,814		21
22	Employee Benefits & Payroll Taxes			470,076	470,076		470,076		470,076		22
23	Inservice Training & Education			2,578	2,578		2,578		2,578		23
24	Travel and Seminar			855	855		855		855		24
25	Other Admin. Staff Transportation			5,716	5,716	(2,858)	2,858		2,858		25
26	Insurance-Prop.Liab.Malpractice			49,839	49,839		49,839	55,243	105,082		26
27	Other (specify):* See Att Sch VI	58,065		46,696	104,761		104,761	(104,761)			27
28	TOTAL General Administration	289,852	38,034	1,055,839	1,383,725	(2,858)	1,380,867	(126,455)	1,254,412		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,740,933	1,138,801	1,938,349	5,818,083		5,818,083	(126,455)	5,691,628		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.

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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			103,742	103,742		103,742	270,801	374,543			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,591	6,591		6,591	453,193	459,784			32
33	Real Estate Taxes							140,400	140,400			33
34	Rent-Facility & Grounds			802,037	802,037		802,037	(802,037)				34
35	Rent-Equipment & Vehicles			5,590	5,590		5,590		5,590			35
36	Other (specify):* See Att Sch V							8,589	8,589			36
37	TOTAL Ownership			917,960	917,960		917,960	70,946	988,906			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			56,743	56,743		56,743		56,743			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			7,129	7,129		7,129		7,129			41
42	Provider Participation Fee			66,248	66,248		66,248		66,248			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			130,120	130,120		130,120		130,120			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,740,933	1,138,801	2,986,429	6,866,163		6,866,163	(55,508)	6,810,655			45

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

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VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		V-30		9
10	Interest and Other Investment Income	(4,964)	V-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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(44,656)	V-27		24
25	Fund Raising, Advertising and Promotional	(78,667)	V20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Att Sch VII	(71,948)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (200,235)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	139,295		34
35	Other- Attach Schedule See Att Sch III	5,432		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 144,727		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (55,508)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
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	0	49

STATE OF ILLINOIS

Summary B

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	139,295	0	0	0	0	0	0	0	0	0	139,295	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	139,295	0	139,295	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	139,295	0	139,295	45								

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None	N/A	See Attached Schedule I		See Attached Schedule I		

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	34 Facility Rent	\$ 802,037	Galesburg North Seminary, LLC	N/A	\$ 941,332	\$ 139,295	1
2	V							2
3	V							3
4	V							4
5	V			See Att Schedule V & Independent Accountant's Report				5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 802,037			\$ 941,332	\$ *	139,295 14

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

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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	See Attached Schedule II & III								\$ 3,048	18-7	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	\$ 3,048		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

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VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Unlimited Development, Inc.

Street Address

285 S Farnham

City / State / Zip Code

Galesburg, IL 61401

Phone Number

(309) 343-1550

Fax Number

(309) 343-2857

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	See Att Schedule II & III							5,432	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				\$	\$		\$	5,432

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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										
										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	Cambridge Realty Capital					\$		\$		\$	1								
2	LTD. Of Illinois	X	Facility purchase	\$47,507.82	7/1/2005		9,180,000	8,759,144	8/1/2040	5.2000	458,157	2							
3												3							
4												4							
5												5							
Working Capital																			
6	Miscellaneous	X									6,591	6							
7	Less Interest Income	X									(4,964)	7							
8												8							
9	TOTAL Facility Related			\$47,507.82		\$	9,180,000	\$ 8,759,144			\$ 459,784	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related					\$		\$			\$	14							
15	TOTALS (line 9+line14)					\$	9,180,000	\$ 8,759,144			\$ 459,784	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 44,052 Line # 26

* 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.)

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,680 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>4.33 Acres</u>	<u>2005</u>	<u>\$ 287,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	#VALUE!		\$ 287,000	3

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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	121		2005		\$ 9,633,067	\$ 240,827	40	\$ 240,827	\$	\$ 1,003,445	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Fire Door Closers	2005		3,059	204	15	204		782	9
10		Air conditioners	2006		9,942	994	10	994		3,479	10
11		Electric Sign-Double Face	2006		39,915	3,992	10	3,992		14,637	11
12		Concrete	2006		6,963	464	15	464		1,547	12
13		Asphalt Drive	2006		7,360	920	8	920		3,067	13
14		Door w/ side Windows	2006		3,103	207	15	207		673	14
15		Dining Room Addition	2006		4,501	300	15	300		950	15
16		Door Alarm	2006		3,177	318	10	318		980	16
17		Phone Modem	2006		2,906	581	5	581		1,791	17
18		Air conditioner	2007		4,921	492	10	492		1,312	18
19		Marble Vinyl Floor Tile	2007		2,904	290	10	290		846	19
20		Dining room cabinetry	2007		2,100	140	15	140		408	20
21		Concrete sidewalk	2007		4,480	299	15	299		847	21
22		Euromarble vinyl tile	2007		4,482	448	10	448		1,270	22
23		Roof/roof deck repair	2007		62,606	6,261	10	6,261		16,696	23
24		Deck Repair/roof replacement	2007		12,474	1,247	10	1,247		3,534	24
25		Window treatments	2007		3,624	725	5	725		1,510	25
26		Roof replacement	2007		26,251	2,625	10	2,625		7,000	26
27		Roof	2008		10,625	1,063	10	1,063		1,594	27
28		Roof	2008		15,195	1,520	10	1,520		2,280	28
29		Roof	2008		15,580	1,558	10	1,558		2,207	29
30		Roof	2008		4,633	463	10	463		656	30
31		Fire Dampers	2008		6,438	644	10	644		751	31
32		Condensor	2008		3,548	237	15	237		316	32
33		Sidewalks	2008		2,887	192	15	192		240	33
34		Prime Walls/Paint	2008		4,560	912	5	912		988	34
35		Condensing units/Refrigeration Piping	2008		6,352	423	15	423		776	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Seminary Manor

0047233

Report Period Beginning:

10/1/08

Ending:

9/30/09

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	Air conditioner	2008	\$ 3,408	\$ 682	5	\$ 682	\$	\$ 1,250	37
38	Hand rail	2008	2,781	185	15	185		340	38
39	Double door with Sidelights	2008	12,030	1,203	10	1,203		2,206	39
40	Roof Repairs	2008	25,054	2,505	10	2,505		3,758	40
41	Roof Repairs-Garage	2008	4,550	455	10	455		569	41
42	Sprinklers	2008	2,726	109	25	109		136	42
43	Lighting Pole	2009	6,677	668	10	668		668	43
44	Replace wall/ceiling sheetrock, tile, paint	2009	39,005	2,438	12	2,438		2,438	44
45	Roof replacement	2009	9,574	878	10	878		878	45
46	Rubber flooring	2009	14,397	1,320	10	1,320		1,320	46
47	Light posts concrete	2009	3,690	246	15	246		246	47
48	Parking lot light poles	2009	6,505	434	15	434		434	48
49	Parking lot (asphalt)	2009	40,752	5,094	8	5,094		5,094	49
50	Tile	2009	4,267	107	20	107		107	50
51	Waterheater	2009	7,074	295	10	295		295	51
52	Shower room	2009	30,990	1,033	15	1,033		1,033	52
53	Seminary Manor PT Addition	2009	152,233	5,074	25	5,074		5,074	53
54	Seminary Manor Garden Court Addition	2009	131,812	4,394	25	4,394		4,394	54
55	Concrete Paking Lot & Sidewalk	2009	12,869	286	15	286		286	55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 10,418,047	\$ 295,752		\$ 295,752	\$	\$ 1,105,108	70

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

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	\$ 617,422	\$ 63,541	\$ 63,541	\$	3-15 yrs	\$ 218,153	71
72	Current Year Purchases	57,244	1,629	1,629		10-15 yrs	1,629	72
73	Fully Depreciated Assets							73
74	Indirect Costs		883	883				74
75	TOTALS	\$ 674,666	\$ 66,053	\$ 66,053	\$		\$ 219,782	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 Care	2008 Ford E450 Universal	2008	\$ 50,950	\$ 12,738	\$ 12,738	\$	4 yrs	\$ 13,799	76
77										77
78										78
79										79
80	TOTALS			\$ 50,950	\$ 12,738	\$ 12,738	\$		\$ 13,799	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)	\$ 11,430,663	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 374,543	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 374,543	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)	\$ 1,338,689	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	2002 Ford F 250 - 2006	\$ 21,200	\$ 5,300	\$ 18,108	86
87	2006 Toyota Corolla - 2006	14,900	3,725	12,417	87
88					88
89					89
90					90
91	TOTALS	\$ 36,100	\$ 9,025	\$ 30,525	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>See Attached</u>			3
4	Additions				<u>Schedule V</u>			4
5					<u>Related Party</u>			5
6					<u>Lease</u>			6
7	TOTAL				\$ _____			7

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

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A.

9. Option to Buy: YES NO Terms: N/A *

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: \$ 5,590 Description: See Attached Schedule XIII

(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 \$ N/A

13. /2011 \$ N/A

14. /2012 \$ N/A

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input 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>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							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): _____									13
14	TOTAL			\$		\$	\$		\$	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 Seminary Manor

0047233

Report Period Beginning: 10/1/08

Ending: 9/30/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/09 (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	\$ 205,059	\$ 301,789	1
2	Cash-Patient Deposits	15,544	15,544	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>27,163</u>)	1,189,232	1,189,232	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	92,048	139,107	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Att Sch VIII</u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,501,883	\$ 1,645,672	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		287,000	13
14	Buildings, at Historical Cost		9,659,320	14
15	Leasehold Improvements, at Historical Cost	758,727	758,727	15
16	Equipment, at Historical Cost	406,783	761,716	16
17	Accumulated Depreciation (book methods)	(210,881)	(1,369,214)	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): <u>See Att Sch VIII</u>		265,338	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 954,629	\$ 10,362,887	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,456,512	\$ 12,008,559	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 206,639	\$ 105,954	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,544	15,544	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	60,366	60,366	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,641	22,641	31
32	Accrued Real Estate Taxes(Sch.IX-B)		101,797	32
33	Accrued Interest Payable	4,940	42,896	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Interdivision Payable</u>	645,168	2,045,775	36
37	<u>Deficient Mortgage Escrow Acct</u>		12,641	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 955,298	\$ 2,407,614	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,759,144	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44	<u>Security Deposits</u>	32,500	32,500	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 32,500	\$ 8,791,644	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 987,798	\$ 11,199,258	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,468,714	\$ 809,301	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,456,512	\$ 12,008,559	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,008,665	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,008,665	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	460,049	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)	\$ 460,049	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,468,714	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Seminary Manor# 0047233Report Period Beginning: 10/1/08Ending: 9/30/09

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	\$ 7,178,897	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,178,897	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	102,372	6
7	Oxygen	7,052	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 109,424	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	11,055	12
13	Barber and Beauty Care	7,351	13
14	Non-Patient Meals	4,871	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	(179)	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 23,098	23
D. Non-Operating Revenue			
24	Contributions	1,401	24
25	Interest and Other Investment Income***	4,964	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,365	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Activity Fund Income</u>		28
28a	<u>See Att Schedule XII</u>	8,428	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,428	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,326,212	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,333,373	31
32	Health Care	3,100,985	32
33	General Administration	1,383,725	33
B. Capital Expense			
34	Ownership	917,960	34
C. Ancillary Expense			
35	Special Cost Centers	63,872	35
36	Provider Participation Fee	66,248	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,866,163	40
41	Income before Income Taxes (line 30 minus line 40)**	460,049	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 460,049	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 Seminary Manor

0047233

Report Period Beginning:

10/1/08

Ending:

9/30/09

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,908	2,030	\$ 62,932	\$ 31.00	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	4,878	5,189	110,939	21.38	3
4	Licensed Practical Nurses	26,755	28,463	497,250	17.47	4
5	CNAs & Orderlies	103,595	110,207	1,012,806	9.19	5
6	CNA Trainees					6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides	1,004	1,068	11,211	10.50	8
9	Activity Director			0		9
10	Activity Assistants	7,953	8,461	80,102	9.47	10
11	Social Service Workers	3,228	3,434	34,336	10.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,974	31,887	287,555	9.02	15
16	Dishwashers					16
17	Maintenance Workers	3,740	3,978	61,249	15.40	17
18	Housekeepers	12,256	13,039	110,697	8.49	18
19	Laundry	5,910	6,288	50,804	8.08	19
20	Administrator	1,955	2,080	132,630	63.76	20
21	Assistant Administrator	1,850	1,968	29,517	15.00	21
22	Other Administrative	2,274	2,419	58,065	24.00	22
23	Office Manager					23
24	Clerical	6,551	6,969	69,640	9.99	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	2,577	2,742	24,678	9.00	31
32	Other Health Care(specify)	5,544	5,898	106,522	18.06	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	221,952	236,120	\$ 2,740,933 *	\$ 11.61	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	***	\$ 10,645	1-3	35
36	Medical Director	***	33,595	9-3	36
37	Medical Records Consultant	***	0	10-3	37
38	Nurse Consultant	***	1,470	10-3	38
39	Pharmacist Consultant	***	1,650	10-3	39
40	Physical Therapy Consultant	***	300,569	10a-3	40
41	Occupational Therapy Consultant	***	207,138	10a-3	41
42	Respiratory Therapy Consultant	***	0	10a-3	42
43	Speech Therapy Consultant	***	74,315	10a-3	43
44	Activity Consultant	***	0	11-3	44
45	Social Service Consultant	***	0	12-3	45
46	Other(specify) Dental Consultant	***	0	10-3	46
47					47
48	*** Monthly fee				48
49	TOTAL (lines 35 - 48)		\$ 629,382		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 Seminary Manor# 0047233Report Period Beginning: 10/1/08Ending: 9/30/09**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. See Page 21 section F
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes - IHCA dues If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (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? 13 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 33,201 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 66,248
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 benefits on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 0
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation. N/A
- 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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- 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: McGladrey & Pullen, 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 services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.