

		FOR BHF USE					

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**2009**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2009)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH License ID Number:</b> <u>0018002</u></p> <p><b>Facility Name:</b> <u>The Tillers Nursing and Rehabilitation Center</u></p> <p><b>Address:</b> <u>4390 Route 71</u> <u>Oswego</u> <u>60543</u>          Number City Zip Code</p> <p><b>County:</b> <u>Kendall</u></p> <p><b>Telephone Number:</b> <u>(630) 554-1001</u> <b>Fax #</b> <u>(630) 554-1668</u></p> <p><b>HFS ID Number:</b> <u>362728962001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>08/01/72</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Jeremy M. Brune</u> <b>Telephone Number:</b> <u>(779) 875-3979</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/09</u> to <u>12/31/09</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Robert M. Saxon</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>Administrator</u></td> </tr> <tr> <td rowspan="4"><b>Paid Preparer</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Jeremy M. Brune</u></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>Jeremy M. Brune, CPA</u> <u>2508 Riverwalk Drive Plainfield, IL 60586</u></td> </tr> <tr> <td>(Telephone) <u>(779) 875-3979</u> Fax # <u>(866) 416-5355</u></td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>      201 S. Grand Avenue East      Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) <u>Robert M. Saxon</u> (Date) _____		(Title) <u>Administrator</u>	<b>Paid Preparer</b>	(Signed) _____	(Print Name and Title) <u>Jeremy M. Brune</u>	(Firm Name & Address) <u>Jeremy M. Brune, CPA</u> <u>2508 Riverwalk Drive Plainfield, IL 60586</u>	(Telephone) <u>(779) 875-3979</u> Fax # <u>(866) 416-5355</u>
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Facility Name & ID Number The Tillers Nursing and Rehabilitation Center

# 0018002 Report Period Beginning: 01/01/09 Ending: 12/31/09

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 01/12/09

	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	9	Intermediate (ICF)	16	5,763	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	106	38,613	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	1,138	15,951	11,140	28,229	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,138	15,951	11,140	28,229	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.11%

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 08/01/72

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 46 and days of care provided 10,863

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

\* 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:      01/01/09      Ending:      12/31/09

**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
	<b>A. General Services</b>										
1	Dietary	350,747	26,984	7,790	385,521		385,521		385,521		1
2	Food Purchase		231,304		231,304		231,304	(13,877)	217,427		2
3	Housekeeping	290,104	38,685		328,788		328,788		328,788		3
4	Laundry		9,463		9,463		9,463		9,463		4
5	Heat and Other Utilities			153,964	153,964		153,964		153,964		5
6	Maintenance	171,876	53,039	135,968	360,883		360,883		360,883		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	812,726	359,474	297,722	1,469,922		1,469,922	(13,877)	1,456,045		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	2,834,114	183,724	39,230	3,057,068		3,057,068		3,057,068		10
10a	Therapy	91,578			91,578		91,578		91,578		10a
11	Activities	93,263	14,341	2,627	110,232		110,232		110,232		11
12	Social Services	71,283		1,979	73,261		73,261		73,261		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,090,238	198,065	55,835	3,344,138		3,344,138		3,344,138		16
	<b>C. General Administration</b>										
17	Administrative	386,233			386,233		386,233		386,233		17
18	Directors Fees										18
19	Professional Services			94,403	94,403		94,403	(6,667)	87,736		19
20	Dues, Fees, Subscriptions & Promotions			70,794	70,794		70,794	(45,392)	25,402		20
21	Clerical & General Office Expenses	223,661	11,133	178,934	413,728		413,728	(88,956)	324,772		21
22	Employee Benefits & Payroll Taxes			870,018	870,018		870,018	60,655	930,673		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,338	10,338		10,338		10,338		24
25	Other Admin. Staff Transportation			1,715	1,715		1,715		1,715		25
26	Insurance-Prop.Liab.Malpractice			66,858	66,858		66,858	8,780	75,638		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	609,894	11,133	1,293,060	1,914,088		1,914,088	(71,580)	1,842,508		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,512,858	568,672	1,646,618	6,728,148		6,728,148	(85,457)	6,642,691		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 Tillers Nursing and Rehabilitation Center      #0018002      Report Period Beginning:      01/01/09      Ending:      12/31/09

## 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	
	<b>D. Ownership</b>											
30	Depreciation			181,543	181,543		181,543	197,950	379,493			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,887	27,887		27,887	104,764	132,651			32
33	Real Estate Taxes			74,957	74,957		74,957		74,957			33
34	Rent-Facility & Grounds			508,723	508,723		508,723	(508,723)	(0)			34
35	Rent-Equipment & Vehicles			28,095	28,095		28,095	7,750	35,845			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			821,205	821,205		821,205	(198,259)	622,946			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		487,383	1,086,446	1,573,829		1,573,829	(100,942)	1,472,887			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,920	57,920		57,920		57,920			42
43	Other (specify):* <b>Marketing</b>			16,201	16,201		16,201	(16,201)	(0)			43
44	<b>TOTAL Special Cost Centers</b>		487,383	1,160,567	1,647,950		1,647,950	(117,143)	1,530,807			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,512,858	1,056,055	3,628,390	9,197,303		9,197,303	(400,859)	8,796,444			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.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(13,877)	02		4
5	Telephone, TV & Radio in Resident Rooms	(13,684)	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	105,803	30		9
10	Interest and Other Investment Income	(14,712)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,377)	21		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	(3,011)	21		19
20	Contributions	(1,180)	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	(59,270)	21		24
25	Fund Raising, Advertising and Promotional	(20,558)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(23,223)	20		28
29	Other-Attach Schedule	(71,421)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (119,510)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	(281,349)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (281,349)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (400,859)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

**BHF USE ONLY**

48		49		50		51		52	
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The Tillers Nursing and Rehabilitation Center

ID# 0018002

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	State Replacement Tax	\$ (3,500)	21	1
2	Website	(10,427)	21	2
3	Marketing Expenses	(16,201)	43	3
4	Association Dues - IHCA PAC	(481)	20	4
5	Non-Allowable Legal Fees	(6,667)	19	5
6				6
7				7
8				8
9				9
10	Tillers Real Estate, LLC - Bank Fees	(300)	21	10
11	Tillers Real Estate, LLC - State Replacement Tax	(4,877)	21	11
12	Tillers Real Estate, LLC - Professional Fees	(8,643)	19	12
13	Tillers Real Estate, LLC - Life Insurance	(6,084)	21	13
14	Tillers Real Estate, LLC - Amortization	(862)	31	14
15	Legacy Rehac, LLC - Professional Fees	(5,595)	19	15
16	Legacy Rehac, LLC - Amortization	(7,784)	31	16
17				17
18				18
19				19
20				20
21				21
22				22
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37				37
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(71,421)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Tillers Nursing and Rehabilitation Center# 0018002

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(13,877)	0	0	0	0	0	0	0	0	0	0	(13,877)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL General Services</b>	<b>(13,877)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(13,877)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(20,905)	8,643	5,595	0	0	0	0	0	0	0	0	(6,667)	19
20	Fees, Subscriptions & Promotions	(45,442)	0	50	0	0	0	0	0	0	0	0	(45,392)	20
21	Clerical & General Office Expenses	(105,530)	11,261	5,313	0	0	0	0	0	0	0	0	(88,956)	21
22	Employee Benefits & Payroll Taxes	0	0	60,655	0	0	0	0	0	0	0	0	60,655	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	8,780	0	0	0	0	0	0	0	0	8,780	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(171,877)</b>	<b>19,904</b>	<b>80,393</b>	<b>0</b>	<b>(71,580)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(185,754)</b>	<b>19,904</b>	<b>80,393</b>	<b>0</b>	<b>(85,457)</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Tillers Nursing and Rehabilitation Center# 0018002

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	105,803	86,929	5,218	0	0	0	0	0	0	0	0	197,950	30
31	Amortization of Pre-Op. & Org.	(8,646)	862	7,784	0	0	0	0	0	0	0	0	0	31
32	Interest	(14,712)	119,476	0	0	0	0	0	0	0	0	0	104,764	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(508,723)	0	0	0	0	0	0	0	0	0	(508,723)	34
35	Rent-Equipment & Vehicles	0	0	7,750	0	0	0	0	0	0	0	0	7,750	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>82,445</b>	<b>(301,456)</b>	<b>20,752</b>	<b>0</b>	<b>(198,259)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	(100,942)	0	0	0	0	0	0	0	0	(100,942)	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):*	(16,201)	0	0	0	0	0	0	0	0	0	0	(16,201)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(16,201)</b>	<b>0</b>	<b>(100,942)</b>	<b>0</b>	<b>(117,143)</b>	<b>44</b>							
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(119,510)	(281,552)	203	0	0	0	0	0	0	0	0	(400,859)	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
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%					
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	\$ 508,723	Tillers Real Estate, LLC	100.00%	\$	\$ (508,723)	1
2	V	32 Interest Income	161	Tillers Real Estate, LLC	100.00%		(161)	2
3	V	21 Office and Supplies		Tillers Real Estate, LLC	100.00%			3
4	V	21 Bank Service Fees		Tillers Real Estate, LLC	100.00%	300	300	4
5	V	21 Replacement Tax		Tillers Real Estate, LLC	100.00%	4,877	4,877	5
6	V	21 Life Insurance		Tillers Real Estate, LLC	100.00%	6,084	6,084	6
7	V	32 Interest Expense		Tillers Real Estate, LLC	100.00%	119,637	119,637	7
8	V	19 Professional Fees		Tillers Real Estate, LLC	100.00%	8,643	8,643	8
9	V	30 Depreciation		Tillers Real Estate, LLC	100.00%	86,929	86,929	9
10	V	31 Amortization		Tillers Real Estate, LLC	100.00%	862	862	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 508,884			\$ 227,332	\$ * (281,552)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Ancillary Revenue	\$ 432,868	Legacy Rehab, LLC	100.00%	\$	\$ (432,868)
16	V	19 Professional Fees		Legacy Rehab, LLC	100.00%	5,595	5,595
17	V	20 Dues and Subscriptions		Legacy Rehab, LLC	100.00%	50	50
18	V	21 Office and Clerical		Legacy Rehab, LLC	100.00%	5,313	5,313
19	V	22 Employee Benefits		Legacy Rehab, LLC	100.00%	60,655	60,655
20	V	26 Liability Insurance		Legacy Rehab, LLC	100.00%	8,780	8,780
21	V	30 Depreciation		Legacy Rehab, LLC	100.00%	5,218	5,218
22	V	31 Amortization		Legacy Rehab, LLC	100.00%	7,784	7,784
23	V	35 Rent - Equipment		Legacy Rehab, LLC	100.00%	7,750	7,750
24	V	39 Ancillary Salary		Legacy Rehab, LLC	100.00%	331,926	331,926
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 432,868			\$ 433,071	\$ * 203

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

Facility Name & ID Number      The Tillers Nursing and Rehabilitation Cent      #      0018002      Report Period Beginning:      01/01/09      Ending:      12/31/09

## 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	\$ 195,300	17 - 01	1
2	Brett Saxon	Relative	Asst. Admin.	0.00	0	40	100.00	Salary	123,062	17 - 01	2
3	Brooke Saxon - Spencer	Relative	Assc. Admin.	0.00	0	30	100.00	Salary	67,871	17 - 01	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 386,233		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 # 0018002 Report Period Beginning: 01/01/09 Ending: 12/31/09

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 Tillers Real Estate, LLC  
 Street Address 4390 Route 71  
 City / State / Zip Code Oswego, IL60543  
 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

Facility Name & ID Number The Tillers Nursing and Rehabilitation Center # 0018002 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

Name of Related Organization Legacy Rehab, LLC  
 Street Address 4390 Route 71  
 City / State / Zip Code Oswego, IL60543  
 Phone Number ( )  
 Fax Number ( )

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
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 # 0018002 Report Period Beginning: 01/01/09 Ending: 12/31/09

**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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Allied Bank		X	Room Renovations	\$9,759.93		\$ 1,400,000	\$ 1,392,341	6.7500	\$ 27,887	1								
2	Allied Bank- Tillers R.E.		X	Therapy Addition	\$11,821.26		1,600,000	1,577,781	7.3750	119,637	2								
3											3								
4											4								
5											5								
<b>Working Capital</b>																			
6											6								
7											7								
8											8								
9	<b>TOTAL Facility Related</b>				\$21,581.19		\$ 3,000,000	\$ 2,970,122		\$ 147,524	9								
<b>B. Non-Facility Related*</b>																			
10	Interest Income									(14,712)	10								
11	Interest Income- Tillers R.E.									(161)	11								
12											12								
13											13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$ (14,873)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 3,000,000	\$ 2,970,122		\$ 132,651	15								

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.)





**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 39,500 B. General Construction Type: Exterior Brick Frame Brick 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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1985</u>	<u>\$ 77,820</u>	<u>1</u>
2	<u>Tillers Real Estate</u>			<u>100,000</u>	<u>2</u>
3	<b>TOTALS</b>			<b>\$ 177,820</b>	<b>3</b>

**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	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
<b>Improvement Type**</b>										
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	866	866	17,312	17
18	Various		1990	113,441		20	5,672	5,672	107,769	18
19	Various		1991	34,778		20	1,739	1,739	31,300	19
20	Various		1992	11,969		20	598	598	10,174	20
21	Various		1993	14,346		20	717	717	11,477	21
22	Various		1995	32,441		20	1,622	1,622	22,709	22
23	Various		1996	21,503		20	1,075	1,075	13,977	23
24	Various		1997	3,235		20	162	162	1,941	24
25	Various		1998	69,777		20	3,489	3,489	38,377	25
26	Various		1999	158,719		20	7,936	7,936	79,360	26
27	Various		2000	67,355		20	3,368	3,368	30,310	27
28	Various		2001	45,387		20	2,269	2,269	18,155	28
29	Various		2002	56,267		20	2,813	2,813	19,693	29
30	Various		2003	34,778		20	1,739	1,739	10,433	30
31	Various		2004	147,448		20	7,372	7,372	36,862	31
32	Various		2005	182,814		20	9,141	9,141	36,563	32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number The Tillers Nursing and Rehabilitation Center

# 0018002

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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	Concrete	2006	\$ 5,830	\$	20	\$ 292	\$ 292	\$ 1,166	37
38	Sidewalks	2006	5,360		20	268	268	1,072	38
39	Fire Spinkler Sysem	2006	9,984		20	499	499	1,997	39
40	Fence	2006	7,391		20	370	370	1,478	40
41	Sprinkler Alarm System	2006	6,200		20	310	310	1,240	41
42	Roofing	2006	51,480		20	2,574	2,574	10,296	42
43	Sprinkler System	2006	21,394		20	1,070	1,070	4,279	43
44	Wall Coverings	2006	16,748		20	837	837	3,350	44
45	Flooring	2006	11,094		20	555	555	2,219	45
46	Carpeting	2006	16,060		20	803	803	3,212	46
47	Heat Exchanger	2006	3,073		20	154	154	615	47
48	Water Heater	2006	2,815		20	141	141	563	48
49	Folding Partition	2006	2,765		20	138	138	553	49
50	Water Heater	2006	8,065		20	403	403	1,613	50
51	Dishwasher Room Doorway & Dining Room Floor	2007	3,438		20	172	172	516	51
52	Door Locks	2007	2,841		20	142	142	426	52
53	Door Alarms	2007	5,892		20	295	295	884	53
54	Door Alarms	2007	5,500		20	275	275	825	54
55	Door Alarms	2007	236		20	12	12	35	55
56	Door Alarms - Touchpads	2007	465		20	23	23	70	56
57	Door Alarms - Touchpads	2007	3,480		20	174	174	522	57
58	Door Alarms	2007	665		20	33	33	100	58
59	Door Alarm System	2007	2,051		20	103	103	308	59
60	Door Alarm System	2007	337		20	17	17	51	60
61	Doors	2007	3,075		20	154	154	461	61
62	Door Alarm	2007	623		20	31	31	93	62
63	Door Alarm	2007	700		20	35	35	105	63
64	Roof	2007	68,720		20	3,436	3,436	10,308	64
65	Laminate Flooring	2007	1,393		20	70	70	209	65
66	Door Alarm - Access System	2007	11,770		20	589	589	1,766	66
67	Thermostat	2007	1,951		20	98	98	293	67
68	Repair Hot Water System	2007	3,712		20	186	186	557	68
69	Repair Water Lines & Plumbing	2007	10,426		20	521	521	1,564	69
70	TOTAL (lines 4 thru 69)		\$ 3,578,283	\$		\$ 65,355	\$ 65,355	\$ 2,810,333	70

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

Facility Name &amp; ID Number The Tillers Nursing and Rehabilitation Center

# 0018002

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,578,283	\$		\$ 65,355	\$ 65,355	\$ 2,810,333	1
2	Repair Broken Sewer Line	2007	6,814		20	341	341	1,022	2
3	Repair Pipes in Kitchen	2007	4,218		20	211	211	633	3
4	Nurses' Office	2007	17,484		20	874	874	2,623	4
5	Heater, Tin Work on Gas Pipe for Laundry	2007	16,045		20	802	802	2,407	5
6	Gait Door and Lock	2008	2,445		20	122	122	245	6
7	Gait Lock	2008	1,285		20	64	64	129	7
8	Roofing	2008	34,980		20	1,749	1,749	3,498	8
9	Flooring	2008	7,000		20	350	350	700	9
10	Alarm System	2008	4,080		20	204	204	408	10
11	Therapy Gym Construction Addition	2008	1,452,534		20	72,627	72,627	145,253	11
12	Landscaping	2008	35,827		20	1,791	1,791	3,583	12
13	Therapy Gym Construction Addition - Final Costs	2009	42,856		20	1,071	1,071	1,071	13
14	Annunciator Panel Rewire	2009	4,500		20	113	113	113	14
15	Annunciator Panel	2009	2,036		20	51	51	51	15
16	Entry Sign Design	2009	1,980		20	50	50	50	16
17	500 Wing - Architect / Construction / Permits	2009	156,982		20	3,925	3,925	3,925	17
18	Resident Room Renewal - Flooring / Electrical / Wiring / Etc	2009	1,325,144		20	33,129	33,129	33,129	18
19	Omark 7.5 KW Heater	2009	1,800		20	45	45	45	19
20	Smoke Detectors	2009	500		20	13	13	13	20
21	Smoke Detectors	2009	500		20	13	13	13	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30	Tillers Nursing & Rehabilitation Center - Depreciation			181,543			(181,543)		30
31	Tillers Real Estate, LLC - Depreciation			86,929			(86,929)		31
32	Legacy Rehab, LLC - Depreciation			5,218			(5,218)		32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,697,293	\$ 273,690		\$ 182,898	\$ (90,792)	\$ 3,009,240	34

\*\*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	\$ 1,597,943	\$	\$ 159,794	\$ 159,794	10	\$ 1,472,489	71
72	Current Year Purchases	646,013		32,301	32,301	10	32,301	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,243,956	\$	\$ 192,095	\$ 192,095		\$ 1,504,790	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	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 - 02	2006	22,500		4,500	4,500	5	18,000	78
79										79
80	TOTALS			\$ 61,262	\$	\$ 4,500	\$ 4,500		\$ 56,762	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)	\$ 9,180,331	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 273,690	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 379,493	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 105,803	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,570,792	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: \$ 35,845 Description: Telephone Equipment - \$18,375, Copier Lease - \$9,720, Legacy Rehab, LLC - \$7,750

(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.

**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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	458,996	\$		\$	458,996	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				75,867				75,867	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				479,493				479,493	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					473,638			473,638	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>Medical Supplies</u>	39 - 02						13,745			13,745	12
13	Other (specify): <u>Lab / X-Ray / Other</u>	39 - 03					72,090				72,090	13
14	<b>TOTAL</b>			\$		\$	1,086,446	\$	487,383	\$	1,573,829	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 Tillers Nursing and Rehabilitation Center**

# **0018002**

Report Period Beginning: **01/01/09**

Ending: **12/31/09**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/09** (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 301,797	\$ 326,052	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,360,575	1,360,575	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	29,750	29,750	5
6	Prepaid Insurance	89,019	89,019	6
7	Other Prepaid Expenses	11,822	11,822	7
8	Accounts Receivable (owners or related parties)	9,451	404	8
9	Other(specify): <b>Life Insurance CSV</b>	56,427	56,427	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,858,840	\$ 1,874,048	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	77,820	177,820	13
14	Buildings, at Historical Cost	1,020,122	3,496,709	14
15	Leasehold Improvements, at Historical Cost	2,657,793	2,693,620	15
16	Equipment, at Historical Cost	2,376,173	2,442,680	16
17	Accumulated Depreciation (book methods)	(3,684,383)	(4,738,981)	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): <b>Loan Fees - Unamortized</b>		20,501	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,447,525	\$ 4,092,349	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,306,366	\$ 5,966,398	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 309,005	\$ 309,005	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	298,293	298,293	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	78,610	78,610	32
33	Accrued Interest Payable	6,266	6,266	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,500	3,500	35
<b>Other Current Liabilities(specify):</b>				
36	<b>Accounts Payable (related parties)</b>		4,892	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 695,674	\$ 700,566	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	1,392,341	2,970,122	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,392,341	\$ 2,970,122	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,088,015	\$ 3,670,688	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,218,351	\$ 2,295,710	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,306,366	\$ 5,966,398	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,002,636</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>State Replacement Tax</b>	(2,378)	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,000,258</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	219,937	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants	219,414	<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(221,259)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>218,092</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,218,351</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name & ID Number The Tillers Nursing and Rehabilitation Center# 0018002Report Period Beginning: 01/01/09Ending: 12/31/09

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,159,454	1
2	Discounts and Allowances for all Levels	(2,262,268)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,897,186	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,680,495	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,680,495	8
<b>C. Other Operating Revenue</b>			
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	4,163	13
14	Non-Patient Meals	13,887	14
15	Telephone, Television and Radio	13,684	15
16	Rental of Facility Space		16
17	Sale of Drugs	389,234	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	75,756	19
20	Radiology and X-Ray	21,034	20
21	Other Medical Services	273,727	21
22	Laundry	26,789	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 818,274	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	14,712	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 14,712	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Gain on Sale of Furniture</u>	6,575	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 6,575	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,417,240	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,469,922	31
32	Health Care	3,344,138	32
33	General Administration	1,914,088	33
<b>B. Capital Expense</b>			
34	Ownership	821,205	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,590,030	35
36	Provider Participation Fee	57,920	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,197,303	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	219,937	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 219,937	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? See Attached 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 Tillers Nursing and Rehabilitation Center

# 0018002

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	2,000	2,080	\$ 91,040	\$ 43.77	1
2	Assistant Director of Nursing	968	1,007	33,082	32.85	2
3	Registered Nurses	34,960	36,358	1,108,860	30.50	3
4	Licensed Practical Nurses	12,796	13,308	352,215	26.47	4
5	CNAs & Orderlies	84,951	88,349	1,215,171	13.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,777	3,928	91,578	23.31	8
9	Activity Director	2,103	2,187	40,134	18.35	9
10	Activity Assistants	4,481	4,660	53,129	11.40	10
11	Social Service Workers	4,265	4,436	71,283	16.07	11
12	Dietician					12
13	Food Service Supervisor	2,009	2,089	41,169	19.71	13
14	Head Cook					14
15	Cook Helpers/Assistants	30,876	32,111	309,579	9.64	15
16	Dishwashers					16
17	Maintenance Workers	7,428	7,725	171,876	22.25	17
18	Housekeepers	22,804	23,716	290,104	12.23	18
19	Laundry					19
20	Administrator	2,000	2,080	195,300	93.89	20
21	Assistant Administrator	2,000	2,080	123,062	59.16	21
22	Other Administrative	1,500	1,560	67,871	43.51	22
23	Office Manager					23
24	Clerical	9,914	10,311	223,662	21.69	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	2,271	2,362	33,745	14.29	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	231,103	240,347	\$ 4,512,859 *	\$ 18.78	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	Monthly	\$ 7,790	01 - 03	35
36	Medical Director	Monthly	12,000	09 - 03	36
37	Medical Records Consultant	Quarterly	479	10 - 03	37
38	Nurse Consultant	Monthly	6,813	10 - 03	38
39	Pharmacist Consultant	Monthly	3,842	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	Monthly	2,627	11 - 03	44
45	Social Service Consultant	Monthly	1,979	12 - 03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 35,530		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	192	\$ 9,655	10 - 03	50
51	Licensed Practical Nurses	357	14,040	10 - 03	51
52	Certified Nurse Assistants/Aides	214	4,400	10 - 03	52
53	TOTAL (lines 50 - 52)	762	\$ 28,096		53





Facility Name & ID Number The Tillers Nursing and Rehabilitation Center# 0018002Report Period Beginning: 01/01/09Ending: 12/31/09**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. IHCA - \$5,529
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 106
- (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. \$ 29,814 Line 10-02
- (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.
- 
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 57,920  
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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 13,877
- (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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0%
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: 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? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.