

Facility Name & ID Number The Tillers Nursing & Rehabilitation Center

0018002 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	90	Skilled (SNF)	90	32,850	1
2		Skilled Pediatric (SNF/PED)			2
3	16	Intermediate (ICF)	16	5,840	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,690	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	883	14,561	12,878	28,322	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	883	14,561	12,878	28,322	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.20%

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 72 and days of care provided 12,286

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: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number

The Tillers Nursing & Rehabilitation Center

0018002

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	361,790	29,137	9,334	400,261		400,261		400,261		1
2	Food Purchase		225,505		225,505		225,505	(12,670)	212,835		2
3	Housekeeping	275,111	32,534		307,645		307,645		307,645		3
4	Laundry		11,856		11,856		11,856		11,856		4
5	Heat and Other Utilities			141,241	141,241		141,241		141,241		5
6	Maintenance	149,972	51,962	143,833	345,767		345,767	(50)	345,717		6
7	Other (specify):*										7
8	TOTAL General Services	786,873	350,994	294,408	1,432,275		1,432,275	(12,720)	1,419,555		8
	B. Health Care and Programs										
9	Medical Director			29,325	29,325		29,325		29,325		9
10	Nursing and Medical Records	3,036,791	221,127	48,386	3,306,304		3,306,304		3,306,304		10
10a	Therapy	86,889	905		87,794		87,794		87,794		10a
11	Activities	94,681	14,624	2,523	111,828		111,828		111,828		11
12	Social Services	68,421		2,660	71,081		71,081		71,081		12
13	CNA Training										13
14	Program Transportation			18,375	18,375		18,375	(18,375)			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,286,782	236,656	101,269	3,624,707		3,624,707	(18,375)	3,606,332		16
	C. General Administration										
17	Administrative	401,824			401,824		401,824		401,824		17
18	Directors Fees										18
19	Professional Services			129,127	129,127		129,127	(11,050)	118,077		19
20	Dues, Fees, Subscriptions & Promotions			73,214	73,214		73,214	(49,661)	23,553		20
21	Clerical & General Office Expenses	224,535	11,028	166,879	402,442		402,442	(85,453)	316,989		21
22	Employee Benefits & Payroll Taxes			914,298	914,298		914,298		914,298		22
23	Inservice Training & Education										23
24	Travel and Seminar			16,151	16,151		16,151		16,151		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			78,395	78,395		78,395		78,395		26
27	Other (specify):*										27
28	TOTAL General Administration	626,359	11,028	1,378,064	2,015,451		2,015,451	(146,164)	1,869,287		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,700,014	598,678	1,773,741	7,072,433		7,072,433	(177,259)	6,895,174		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 & Rehabilitation Center

#0018002

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	
	D. Ownership											
30	Depreciation			267,960	267,960		267,960	198,105	466,065			30
31	Amortization of Pre-Op. & Org.							862	862			31
32	Interest			103,381	103,381		103,381	103,748	207,129			32
33	Real Estate Taxes			75,504	75,504		75,504		75,504			33
34	Rent-Facility & Grounds			502,441	502,441		502,441	(502,441)				34
35	Rent-Equipment & Vehicles			33,459	33,459		33,459		33,459			35
36	Other (specify):*											36
37	TOTAL Ownership			982,745	982,745		982,745	(199,726)	783,019			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		610,670	1,282,203	1,892,873		1,892,873	(103,853)	1,789,020			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,035	58,035		58,035		58,035			42
43	Other (specify):* Supplemental	29,227		29,204	58,431		58,431	(58,431)				43
44	TOTAL Special Cost Centers	29,227	610,670	1,369,442	2,009,339		2,009,339	(162,284)	1,847,055			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,729,241	1,209,348	4,125,928	10,064,517		10,064,517	(539,269)	9,525,248			45

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

The Tillers Nursing and Rehabilitation Center, Inc.
Medicaid Cost Report
01/01/10 - 12/31/10

Page 4 Supplemental Schedule

Description	Amount	Allowable
Line 43 - Salary		
Marketing	29,227	-
	<u>29,227</u>	
Line 43 - Other		
Trade / Health Fairs	1,250	
Marketing Sponsorships	6,423	
Center Based Seminars	275	
Center Based Events	5,323	
Printing	15,933	
	<u>29,204</u>	-

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	(12,670)	2		4
5	Telephone, TV & Radio in Resident Rooms	(15,968)	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	119,270	30		9
10	Interest and Other Investment Income	(11,953)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,224)	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	(1,973)	21		19
20	Contributions	(757)	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	(39,521)	21		24
25	Fund Raising, Advertising and Promotional	(22,497)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(26,407)	20		28
29	Other-Attach Schedule	(127,168)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (142,868)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(396,401)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (396,401)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (539,269)		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.

		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

The Tillers Nursing & Rehabilitation Center

ID# 0018002

Report Period Beginning: 01/01/10

Ending: 12/31/10

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount Reference

1	Pg. 19 - Gain on Sale of Equipment	\$ (50)	6	1
2	Pg. 19 - Medi Van Income (To Extent of Expense)	(18,375)	14	2
3	Marketing Sales Calls Expense	(7,339)	21	3
4	Website	(14,132)	21	4
5	Collection Expense	(3,296)	21	5
6	Marketing - Salary	(29,227)	43	6
7	Marketing - Other Expenses	(29,204)	43	7
8	Non-Allowable Legal Fees	(11,050)	19	8
9	Professional Fees	(3,000)	19	9
10	Office and Supplies	(823)	21	10
11	Bank Fees	(290)	21	11
12	Replacement Tax	(4,298)	21	12
13	Life Insurance	(6,084)	21	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	(127,168)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Tillers Nursing & Rehabilitation Center# 0018002 Report Period Beginning:01/01/10

Ending:

12/31/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(12,670)	0	0	0	0	0	0	0	0	0	0	(12,670)	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	(50)	0	0	0	0	0	0	0	0	0	0	(50)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(12,720)	0	0	0	0	0	0	0	0	0	0	(12,720)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(18,375)	0	0	0	0	0	0	0	0	0	0	(18,375)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(18,375)	0	0	0	0	0	0	0	0	0	0	(18,375)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(14,050)	3,000	0	0	0	0	0	0	0	0	0	(11,050)	19
20	Fees, Subscriptions & Promotions	(49,661)	0	0	0	0	0	0	0	0	0	0	(49,661)	20
21	Clerical & General Office Expenses	(96,948)	11,495	0	0	0	0	0	0	0	0	0	(85,453)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(160,659)	14,495	0	(146,164)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(191,754)	14,495	0	(177,259)	29								

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/10 Ending:

12/31/10

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	119,270	78,835	0	0	0	0	0	0	0	0	0	198,105	30
31	Amortization of Pre-Op. & Org.	0	862	0	0	0	0	0	0	0	0	0	862	31
32	Interest	(11,953)	115,701	0	0	0	0	0	0	0	0	0	103,748	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(502,441)	0	0	0	0	0	0	0	0	0	(502,441)	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	107,317	(307,043)	0	0	0	0	0	0	0	0	0	(199,726)	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	(103,853)	0	0	0	0	0	0	0	(103,853)	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):*	(58,431)	0	0	0	0	0	0	0	0	0	0	(58,431)	43
44	TOTAL Special Cost Centers	(58,431)	0	0	(103,853)	0	(162,284)	44						
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(142,868)	(292,548)	0	(103,853)	0	(539,269)	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	\$ 502,441	Tillers Real Estate, LLC	100.00%	\$	\$	(502,441)	1
2	V	32 Interest Income	127	Tillers Real Estate, LLC	100.00%			(127)	2
3	V	19 Professional Fees		Tillers Real Estate, LLC	100.00%	3,000		3,000	3
4	V	21 Office and Supplies		Tillers Real Estate, LLC	100.00%	823		823	4
5	V	21 Bank Fees		Tillers Real Estate, LLC	100.00%	290		290	5
6	V	21 Replacement Tax		Tillers Real Estate, LLC	100.00%	4,298		4,298	6
7	V	21 Life Insurance		Tillers Real Estate, LLC	100.00%	6,084		6,084	7
8	V	30 Depreciation		Tillers Real Estate, LLC	100.00%	78,835		78,835	8
9	V	31 Amortization		Tillers Real Estate, LLC	100.00%	862		862	9
10	V	32 Interest		Tillers Real Estate, LLC	100.00%	115,828		115,828	10
11	V								11
12	V								12
13	V								13
14	Total		\$ 502,568			\$ 210,020	\$ *	(292,548)	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	Therapy Services	\$ 1,207,306	Legacy Rehab, LLC	100.00%	\$ 1,103,453	\$	(103,853)	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total			\$ 1,207,306			\$ 1,103,453	\$ *	(103,853)	39

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

Facility Name & ID Number

The Tillers Nursing & Rehabilitation Center

#

0018002

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	\$ 208,912	17 - 01	1
2	Brett Saxon	Relative	Asst. Admin.	0.00	0	40	100.00	Salary	119,836	17 - 01	2
3	Brooke Saxon-Spencer	Relative	Assoc. Admin.	0.00	0	30	100.00	Salary	73,076	17 - 01	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 401,825		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

The Tillers Nursing and Rehabilitation Center, Inc.
Medicaid Cost Report
01/01/10 - 12/31/10

Page 7 Supplemental Schedule

	Robert Saxon	Brett Saxon	Brooke Saxon- Spencer	Total
Salary	174,980	111,428	62,683	349,091
LTC Insurance	7,632			7,632
Gas	2,057	4,137	2,456	8,650
Auto Lease	13,341		5,367	18,708
Medical Reimbursement	10,902	4,272	2,570	17,744
	<u>208,912</u>	<u>119,836</u>	<u>73,076</u>	<u>401,825</u>

Facility Name & ID Number The Tillers Nursing & Rehabilitation Center

0018002

Report Period Beginning:

01/01/10

Ending: 12/31/10

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, Illinois 60543
 Phone Number (630) 554 - 1001
 Fax Number (630) 554 - 1668

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 & Rehabilitation Center

0018002

Report Period Beginning:

01/01/10

Ending: 12/31/10

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Allied First Bank		X	Room Renovations	\$9,759.93		\$ 1,400,000	\$ 1,368,215		6.7500	\$ 94,800	1							
2	Allied First Bank		X	Commercial Loan	\$2,959.57			141,493		6.7500	5,250	2							
3												3							
4	Allied First Bank - Tillers RE		X	Therapy Addition	\$11,821.26		1,600,000	1,551,754		7.3750	115,828	4							
5												5							
Working Capital																			
6	Allied First Bank		X	Line of Credit				225,000		5.0000	3,331	6							
7												7							
8												8							
9	TOTAL Facility Related				\$24,540.76		\$ 3,000,000	\$ 3,286,462			\$ 219,209	9							
B. Non-Facility Related*																			
10	Interest Income		X								(11,953)	10							
11	Interest Income - Tillers RE	X									(127)	11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (12,080)	14							
15	TOTALS (line 9+line14)						\$ 3,000,000	\$ 3,286,462			\$ 207,129	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.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.		\$	78,610	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	75,918	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,692)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	78,196	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	75,504	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2005	69,292	8
	2006	70,760	9
	2007	73,564	10
	2008	72,117	11
	2009	75,918	12

2010 Real Estate Tax Accrual = \$75,918 * 1.03 = \$78,196

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Tillers Nursing & Rehabilitation Center COUNTY Kendall
 FACILITY IDPH LICENSE NUMBER 0018002
 CONTACT PERSON REGARDING THIS REPORT Jeremy M. Brune
 TELEPHONE (779) 875 - 3979 FAX #: (866) 216 - 5355

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>03-20-202-004</u>	<u>Nursing Home</u>	\$ <u>54,662.82</u>	\$ <u>54,662.82</u>
2. <u>03-17-456-002</u>	<u>Nursing Home</u>	\$ <u>16,613.52</u>	\$ <u>16,613.52</u>
3. <u>03-14-456-001</u>	<u>Nursing Home</u>	\$ <u>4,642.14</u>	\$ <u>4,642.14</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>75,918.48</u></u>	\$ <u><u>75,918.48</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1985	\$ 71,276	1
2	Tillers Real Estate			97,930	2
3	TOTALS			\$ 169,206	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	FOR BHF USE ONLY	Year	Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated	
	Bed*	Acquired	Constructed		Depreciation	in Years	Depreciation		Depreciation	
4	106	1972	1972	\$ 1,157,892	\$	35	\$	\$	\$ 1,157,892	4
5		1981	1981	134,813		20			134,813	5
6		1985	1985	177,791		20			177,791	6
7		1986	1986	613,142		20			613,142	7
8		1987	1987	22,646		20			22,646	8
	Improvement Type**									
9	Various		1981	4,707		20			4,707	9
10	Various		1982	19,113		20			19,113	10
11	Various		1983	6,133		20			6,133	11
12	Various		1984	5,223		20			5,223	12
13	Various		1985	21,935		20			21,935	13
14	Various		1986	87,912		20			87,912	14
15	Various		1987	11,128		20			11,128	15
16	Various		1988	8,744		20			8,744	16
17	Various		1989	17,312		20			17,312	17
18	Various		1990	113,441		20	5,672	5,672	113,441	18
19	Various		1991	34,778		20	1,739	1,739	33,039	19
20	Various		1992	11,969		20	598	598	10,772	20
21	Various		1993	14,346		20	717	717	12,194	21
22	Various		1995	32,441		20	1,622	1,622	25,953	22
23	Various		1996	21,503		20	1,075	1,075	16,127	23
24	Various		1997	3,235		20	162	162	2,265	24
25	Various		1998	69,777		20	3,489	3,489	45,355	25
26	Various		1999	158,719		20	7,936	7,936	95,231	26
27	Various		2000	67,355		20	3,368	3,368	37,045	27
28	Various		2001	45,387		20	2,269	2,269	22,694	28
29	Various		2002	56,267		20	2,813	2,813	25,320	29
30	Various		2003	34,778		20	1,739	1,739	13,911	30
31	Various		2004	147,448		20	7,372	7,372	51,607	31
32	Various		2005	182,814		20	9,141	9,141	54,844	32
33	Various		2006	168,259		20	8,413	8,413	42,065	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 & ID Number The Tillers Nursing & Rehabilitation Center# 0018002

Report Period Beginning:

01/01/10

Ending:

12/31/10**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Dishwasher Room Doorway & Dining Room Floor	2007	\$ 3,438	\$	20	\$ 172	\$ 172	\$ 688	37
38	Door Locks	2007	2,841		20	142	142	568	38
39	Door Alarms	2007	5,892		20	295	295	1,178	39
40	Door Alarms	2007	5,500		20	275	275	1,100	40
41	Door Alarms	2007	236		20	12	12	47	41
42	Door Alarms - Touchpads	2007	465		20	23	23	93	42
43	Door Alarms - Touchpads	2007	3,480		20	174	174	696	43
44	Door Alarms	2007	665		20	33	33	133	44
45	Door Alarm System	2007	2,051		20	103	103	410	45
46	Door Alarm System	2007	337		20	17	17	67	46
47	Doors	2007	3,075		20	154	154	615	47
48	Door Alarm	2007	623		20	31	31	125	48
49	Door Alarm	2007	700		20	35	35	140	49
50	Roof	2007	68,720		20	3,436	3,436	13,744	50
51	Laminate Flooring	2007	1,393		20	70	70	279	51
52	Door Alarm - Access System	2007	11,770		20	589	589	2,354	52
53	Thermostat	2007	1,951		20	98	98	390	53
54	Repair Hot Water System	2007	3,712		20	186	186	742	54
55	Repair Water Lines & Plumbing	2007	10,426		20	521	521	2,085	55
56	Repair Broken Sewer Line	2007	6,814		20	341	341	1,363	56
57	Repair Pipes in Kitchen	2007	4,218		20	211	211	844	57
58	Nurses' Office	2007	17,484		20	874	874	3,497	58
59	Heater, Tin Work on Gas Pipe for Laundry	2007	16,045		20	802	802	3,209	59
60	Gait Door and Lock	2008	2,445		20	122	122	367	60
61	Gait Lock	2008	1,285		20	64	64	193	61
62	Roofing	2008	34,980		20	1,749	1,749	5,247	62
63	Flooring	2008	7,000		20	350	350	1,050	63
64	Alarm System	2008	4,080		20	204	204	612	64
65	Therapy Gym Construction Addition	2008	1,452,534		20	72,627	72,627	217,880	65
66	Landscaping	2008	35,827		20	1,791	1,791	5,374	66
67	Therapy Gym Construction Addition - Final Costs	2009	42,856		20	2,143	2,143	4,286	67
68	Annunciator Panel Rewire	2009	4,500		20	225	225	450	68
69	Annunciator Panel	2009	2,036		20	102	102	204	69
70	TOTAL (lines 4 thru 69)		\$ 5,210,387	\$		\$ 146,095	\$ 146,095	\$ 3,160,383	70

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

Facility Name & ID Number The Tillers Nursing & Rehabilitation Center

0018002

Report Period Beginning:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,210,387	\$		\$ 146,095	\$ 146,095	\$ 3,160,383	1
2	Entry Sign Design	2009	1,980		20	99	99	198	2
3	500 Wing - Architect / Construction / Permits	2009	156,982		20	7,849	7,849	15,698	3
4	Resident Room Renewal - Flooring / Electrical / Wiring / Etc	2009	1,325,144		20	66,257	66,257	132,514	4
5	Qmark 7.5 KW Heater	2009	1,800		20	90	90	180	5
6	Smoke Detectors	2009	500		20	25	25	50	6
7	Smoke Detectors	2009	500		20	25	25	50	7
8	Parking Lot	2010	108,737		20	5,437	5,437	5,437	8
9	Roofing	2010	36,120		20	1,806	1,806	1,806	9
10	Resident Room Renewal - Flooring / Electrical / Wiring / Etc	2010	88,440		20	4,422	4,422	4,422	10
11	Electric Install	2010	2,900		20	145	145	145	11
12	Door Frame, Door, and Hinges	2010	2,235		20	112	112	112	12
13	Therapy Gym Gutters	2010	1,140		20	57	57	57	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	Depreciation - Tillers Nursing and Rehabilitaton Center, Inc.			267,960			(267,960)		28
29	Depreciation - Tillers Real Estate, LLC			78,835			(78,835)		29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,936,865	\$ 346,795		\$ 232,419	\$ (114,376)	\$ 3,321,052	34

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

Facility Name & ID Number The Tillers Nursing & Rehabilitation Center

0018002

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	\$ 2,243,956	\$	\$ 224,396	\$ 224,396	10	\$ 1,729,186	71
72	Current Year Purchases	47,502		4,750	4,750	10	4,750	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,291,458	\$	\$ 229,146	\$ 229,146		\$ 1,733,936	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	2006	22,500		4,500	4,500	5	22,500	78
79										79
80	TOTALS			\$ 61,262	\$	\$ 4,500	\$ 4,500		\$ 61,262	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)	\$ 9,458,791	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 346,795	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 466,065	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 119,270	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,116,250	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.

Facility Name & ID Number The Tillers Nursing & Rehabilitation Center

0018002

Report Period Beginning:

01/01/10

Ending: 12/31/10

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: \$ 33,459

Description: Telephone - \$18,475, Copier - \$14,984

(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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

* 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?</p> <p><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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 552,635	\$		\$ 552,635	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			63,654			63,654	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			591,016			591,016	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				585,161		585,161	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>See Supplemental</u>	39 - 02					25,508		25,508	12
13	Other (specify): <u>See Supplemental</u>	39 - 03				74,897			74,897	13
14	TOTAL			\$		\$ 1,282,203	\$ 610,670		\$ 1,892,872	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.

The Tillers Nursing & Rehabilitation Center, Inc.
Medicaid Cost Report
01/01/10 - 12/31/10

Page 16 Supplemental Schedule

Description	Supplies	Other
Medical Supplies	25,508	
Laboratory		13,683
Radiology		38,119
Ambulance		6,386
Support Services		7,876
Wound Vac		8,834
	<hr/> <hr/>	<hr/> <hr/>
	25,508	74,897

Facility Name & ID Number The Tillers Nursing & Rehabilitation Center# 0018002Report Period Beginning: 01/01/10

Ending:

12/31/10**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/10

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 202,738	\$ 223,141	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,932,169	1,932,169	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	29,750	29,750	5
6	Prepaid Insurance	85,573	85,573	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,851	4,351	8
9	Other(specify): <u>See Supplemental</u>	71,882	71,882	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,323,963	\$ 2,346,866	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	71,276	169,206	13
14	Buildings, at Historical Cost	1,020,122	3,497,849	14
15	Leasehold Improvements, at Historical Cost	2,899,840	2,935,667	15
16	Equipment, at Historical Cost	2,422,462	2,489,379	16
17	Accumulated Depreciation (book methods)	(3,952,343)	(5,085,776)	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):		19,639	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,461,357	\$ 4,025,964	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,785,320	\$ 6,372,830	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 357,720	\$ 327,641	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	366,493	366,493	29
30	Accrued Salaries Payable	315,330	315,330	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	78,196	78,196	32
33	Accrued Interest Payable	9,577	9,577	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Supplemental</u>	22,655		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,149,971	\$ 1,097,237	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,368,215	2,919,969	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,368,215	\$ 2,919,969	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,518,186	\$ 4,017,206	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,267,134	\$ 2,355,624	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,785,320	\$ 6,372,830	48

*(See instructions.)

The Tillers Nursing & Rehabilitation Center, Inc.
Medicaid Cost Report
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Page 17 Supplemental Schedule

Description	Operating	After Consolidation
Line 9 - Other Current Assets		
Life Insurance - Cash Surrender Value	71,882	71,882
	<u>71,882</u>	<u>71,882</u>
Line 23 - Other Long Term Assets		
Loan and Title Fees - Unamortized		19,639
	<u>-</u>	<u>19,639</u>
Line 36 - Other Current Liabilities		
Due to Tillers Real Estate, LLC	22,655	-
	<u>22,655</u>	<u>-</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,218,351	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,218,351	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	100,783	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	65,000	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(117,000)	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)	\$ 48,783	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,267,134	24 *

* This must agree with page 17, line 47.

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	\$ 9,794,613	1
2	Discounts and Allowances for all Levels	(2,643,015)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,151,598	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,885,094	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,885,094	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,917	13
14	Non-Patient Meals	12,669	14
15	Telephone, Television and Radio	15,968	15
16	Rental of Facility Space		16
17	Sale of Drugs	525,242	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	97,446	19
20	Radiology and X-Ray	28,068	20
21	Other Medical Services	307,633	21
22	Laundry	23,926	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,015,869	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	11,953	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,953	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	100,786	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 100,786	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,165,300	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,432,275	31
32	Health Care	3,624,707	32
33	General Administration	2,015,451	33
B. Capital Expense			
34	Ownership	982,745	34
C. Ancillary Expense			
35	Special Cost Centers	1,951,304	35
36	Provider Participation Fee	58,035	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,064,517	40
41	Income before Income Taxes (line 30 minus line 40)**	100,783	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 100,783	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Finished 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.

The Tillers Nursing & Rehabilitation Center, Inc.
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Page 19 Supplemental Schedule

Description	Amount	Page 5 Adjustment
Line 28 - Other Income		
Capital Gain on Sale of Land	69,300	
Capital Gain on Sale of Equipment	50	50
Medi Van Transportation Income	31,436	31,436
	<u>100,786</u>	<u>31,486</u>

The gain on the sale of the land was not adjusted out on Page 5 as historically there has never been a reimburseable expense item (depreciation or repairs) reimbursed by the Illinois Department of Healthcare and Family Services.

Facility Name & ID Number **The Tillers Nursing & Rehabilitation Center**

0018002

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	\$ 91,931	\$ 44.20	1
2	Assistant Director of Nursing	2,000	2,080	75,307	36.21	2
3	Registered Nurses	38,523	40,063	1,240,251	30.96	3
4	Licensed Practical Nurses	12,735	13,245	355,862	26.87	4
5	CNAs & Orderlies	83,875	87,230	1,217,398	13.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,531	3,672	86,889	23.66	8
9	Activity Director	2,033	2,114	39,377	18.63	9
10	Activity Assistants	4,596	4,780	55,304	11.57	10
11	Social Service Workers	4,033	4,195	68,421	16.31	11
12	Dietician					12
13	Food Service Supervisor	1,994	2,073	41,475	20.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	31,478	32,737	320,315	9.78	15
16	Dishwashers					16
17	Maintenance Workers	6,386	6,641	149,972	22.58	17
18	Housekeepers	21,310	22,162	275,111	12.41	18
19	Laundry					19
20	Administrator	2,000	2,080	208,912	100.44	20
21	Assistant Administrator	2,000	2,080	119,836	57.61	21
22	Other Administrative	1,500	1,560	73,076	46.84	22
23	Office Manager					23
24	Clerical	9,806	10,199	224,535	22.02	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	3,715	3,864	56,042	14.50	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	1,277	1,328	29,227	22.01	33
34	TOTAL (lines 1 - 33)	234,792	244,183	\$ 4,729,241 *	\$ 19.37	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		\$ 9,334	01 - 03	35
36	Medical Director		29,325	09 - 03	36
37	Medical Records Consultant		2,311	10 - 03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,564	10 - 03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		2,523	11 - 03	44
45	Social Service Consultant		2,660	12 - 03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 49,717		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 18,173	10 - 03	50
51	Licensed Practical Nurses		6,087	10 - 03	51
52	Certified Nurse Assistants/Aides		18,251	10 - 03	52
53	TOTAL (lines 50 - 52)		\$ 42,511		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	Amount	
Robert Saxon	Administrator	33.34	\$ 208,912	Workers' Compensation Insurance	\$ 86,783	IDPH License Fee	\$		
Brett Saxon	Asst. Admin.	0	119,836	Unemployment Compensation Insurance	46,848	Advertising: Employee Recruitment		3,377	
Brooke Saxon - Spencer	Assc. Admin	0	73,075	FICA Taxes	340,505	Health Care Worker Background Check		4,290	
				Employee Health Insurance	335,006	(Indicate # of checks performed _____)			
				Employee Meals		<u>Patient Background Checks</u>			
				Illinois Municipal Retirement Fund (IMRF)*		Association Dues		10,597	
				Safety Programs	600	Subscriptions and Licenses		5,289	
				Pension	43,393	Yellow Page Advertising		26,407	
				Employee Physicals	5,475	Advertising and Public Relations		22,497	
				Dental and Vision Insurance	13,912				
				Life and Disability Insurance	19,835	Less: Public Relations Expense (_____)			
				Other Employee Benefits	21,941	Non-allowable advertising		(22,497)	
						Yellow page advertising		(26,407)	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 401,824	TOTAL (agree to Schedule V, line 22, col.8)		\$ 914,298	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 23,553
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	Seminar Expense	16,151	
(Attach a copy of any management service agreement)							Entertainment Expense (_____)		
C. Professional Services							TOTAL (agree to Sch. V, line 24, col. 8)		
Vendor/Payee	Type		Amount				\$ 16,151		
ADP	Payroll		\$ 29,541						
Jeremy Brune & Associates	Accounting		20,550						
FR&R	Consulting		1,465						
Ivans	Data Processing		891						
DB Solutions, LLC	IT Support		11,430						
Latimer, Levay & Jurasek	Legal		2,191						
Duane Morris, LLP	Legal		47,035						
Wessels & Sherman PC	Legal		1,309						
Thompson Coburn, LLP	Legal		8,312						
Law Offices of James F. Write	Legal		2,023						
Accumed	Data Processing		4,380						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 129,127						
(If total legal fees exceed \$5,000, attach copy of invoices.)									

* Attach copy of IMRF notifications

**See instructions.

The Tillers Nursing & Rehabilitation Center, Inc.
Medicaid Cost Report
01/01/10 - 12/31/10

Page 21A Supplemental Schedule

Description	Amount	Page 5 Adjustment
Legal Schedule		
Latimer Levay Jurasek LLC	104	104
Wessels & Sherman PC	50	50
Latimer Levay Jurasek LLC	371	371
Latimer Levay Jurasek LLC	53	
Wessels & Sherman PC	50	50
Latimer Levay Jurasek LLC	90	90
Wessels & Sherman PC	50	50
Wessels & Sherman PC	50	50
Wessels & Sherman PC	50	50
Wessels & Sherman PC	50	50
Latimer Levay Jurasek LLC	980	980
Latimer Levay Jurasek LLC	255	255
Latimer Levay Jurasek LLC	338	338
Duane Morris LLP	2,623	
Duane Morris LLP	7,040	
Wessels & Sherman PC	736	50
Duane Morris LLP	4,977	
Duane Morris LLP	7,535	
Duane Morris LLP	6,951	
Duane Morris LLP	6,270	
Wessels & Sherman PC	73	50
Duane Morris LLP	2,831	
Duane Morris LLP	2,145	
Wessels & Sherman PC	50	50
Law Offices of James F. Write	930	
Duane Morris LLP	3,263	
Duane Morris LLP	1,771	
Wessels & Sherman PC	50	50
Duane Morris LLP	474	
Duane Morris LLP	1,155	
Wessels & Sherman PC	50	50
Thompson Coburn LLP	7,304	7,304
Law Offices of James F. Write	1,093	
Thompson Coburn LLP	1,008	1,008
Wessels & Sherman PC	50	50
	60,869	11,050

The Tillers Nursing & Rehabilitation Center, Inc.
Medicaid Cost Report
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Page 21B Supplemental Schedule

Description	Amount	Page 5 Adjustment
Seminar Schedule		
Upstairs Solutions - On Line Employee Training	3,120	
Upstairs Solutions - On Line Employee Training	949	
Upstairs Solutions - On Line Employee Training	420	
Upstairs Solutions - On Line Employee Training	960	
Upstairs Solutions - On Line Employee Training	202	
Upstairs Solutions - On Line Employee Training	161	
Upstairs Solutions - On Line Employee Training	52	
Pharmarica - Pharmacy Services	400	
Pathway Health Services - Medicare Training	9,887	
Total	<u>16,151</u>	

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

(See instructions.)

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

Facility Name & ID Number The Tillers Nursing & Rehabilitation Center# 0018002Report Period Beginning: 01/01/10Ending: 12/31/10**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 - \$
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? 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? 5 - 7 Yrs
- (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. \$ 58,035
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? No
- (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. \$ 12,669
- (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? Ln 14
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. \$ N/A
- (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.