

		FOR BHF USE					

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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>I. IDPH License ID Number: <u>0021790</u></p> <p>Facility Name: <u>NAZARETHVILLE</u></p> <p>Address: <u>300 NORTH RIVER ROAD</u> <u>DES PLAINES</u> <u>60016</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(847) 297-5900</u> Fax # <u>(847) 297-0504</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>01/01/12</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" 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>IRS Exemption Code <u>501C3</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input 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>In the event there are further questions about this report, please contact: Name: <u>Lynda M. Olinski</u> Telephone Number: <u>(708) 478-7916</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501C3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2013</u> to <u>12/31/2013</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%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Michael R. Gordon</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>CFO, Vice President Finance</u></td> </tr> <tr> <td rowspan="4" style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) <u>()</u> Fax # <u>()</u></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Michael R. Gordon</u> (Date) _____		(Title) <u>CFO, Vice President Finance</u>	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____		(Telephone) <u>()</u> Fax # <u>()</u>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																			
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Paid Preparer	(Signed) _____																																				
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	(Print Name and Title) _____																																				
	(Firm Name & Address) _____																																				
	(Telephone) <u>()</u> Fax # <u>()</u>																																				

Facility Name & ID Number NAZARETHVILLE

0021790 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	68	Intermediate (ICF)	68	24,820	3
4		Intermediate/DD			4
5	15	Sheltered Care (SC)	15	5,475	5
6		ICF/DD 16 or Less			6
7	83	TOTALS	83	30,295	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	11,335	11,594		22,929
11	ICF/DD				11
12	SC		4,358		4,358
13	DD 16 OR LESS				13
14	TOTALS	11,335	15,952		27,287

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.07%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/A-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 05/25/79

J. Was the facility purchased or leased after January 1, 1978?

YES Date 01/01/12 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

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		27,946	359	28,305		28,305		28,305		1
2	Food Purchase		648,212		648,212		648,212	(1,577)	646,635		2
3	Housekeeping	153,456	12,727		166,183		166,183		166,183		3
4	Laundry	52,226	825	63,186	116,237		116,237	(21,386)	94,851		4
5	Heat and Other Utilities			186,815	186,815		186,815	1,393	188,208		5
6	Maintenance	135,770	12,595	97,485	245,850		245,850	565	246,415		6
7	Other (specify):* Pastoral Care	38,548	599		39,147		39,147		39,147		7
8	TOTAL General Services	380,000	702,904	347,845	1,430,749		1,430,749	(21,005)	1,409,744		8
	B. Health Care and Programs										
9	Medical Director			2,009	2,009		2,009		2,009		9
10	Nursing and Medical Records	1,867,159	50,712	11,471	1,929,342		1,929,342	(1,231)	1,928,111		10
10a	Therapy										10a
11	Activities	124,976	1,154	2,905	129,035		129,035	417	129,452		11
12	Social Services	31,487	113	1,960	33,560		33,560		33,560		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,023,622	51,979	18,345	2,093,946		2,093,946	(814)	2,093,132		16
	C. General Administration										
17	Administrative	190,693	3,251	485,510	679,454		679,454	136,663	816,117		17
18	Directors Fees										18
19	Professional Services			46,219	46,219		46,219	(34,593)	11,626		19
20	Dues, Fees, Subscriptions & Promotions			7,662	7,662		7,662	3,684	11,346		20
21	Clerical & General Office Expenses			5,763	5,763		5,763	1,511	7,274		21
22	Employee Benefits & Payroll Taxes			790,399	790,399		790,399	16,142	806,541		22
23	Inservice Training & Education							413	413		23
24	Travel and Seminar			521	521		521	1,289	1,810		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			36,823	36,823		36,823	92	36,915		26
27	Other (specify):*										27
28	TOTAL General Administration	190,693	3,251	1,372,897	1,566,841		1,566,841	125,201	1,692,042		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,594,315	758,134	1,739,087	5,091,536		5,091,536	103,382	5,194,918		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 NAZARETHVILLE

#0021790

Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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			82,594	82,594		82,594	(7,670)	74,924			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,363	6,363		6,363	(25,352)	(18,989)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			4,254	4,254		4,254	6,847	11,101			34
35	Rent-Equipment & Vehicles			1,965	1,965		1,965	560	2,525			35
36	Other (specify):*											36
37	TOTAL Ownership			95,176	95,176		95,176	(25,615)	69,561			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		188,223		188,223		188,223		188,223			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			141,787	141,787		141,787		141,787			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		188,223	141,787	330,010		330,010		330,010			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,594,315	946,357	1,976,050	5,516,722		5,516,722	77,767	5,594,489			45

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

Facility Name & ID Number NAZARETHVILLE

0021790

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

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	(2,198)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(21,386)	4		8
9	Non-Straightline Depreciation	9,117	30		9
10	Interest and Other Investment Income	(25,354)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(125,819)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (165,640)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (165,640)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

NAZARETHVILLE

ID# 0021790

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Civil Settlement	\$ (40,000)	19	1
2	Labs	(1,231)	10	2
3	Merger Related Home Office Allocation	(84,588)	17	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(125,819)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number NAZARETHVILLE# 0021790

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	(2,198)	621	0	0	0	0	0	0	0	0	0	(1,577)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(21,386)	0	0	0	0	0	0	0	0	0	0	(21,386)	4
5	Heat and Other Utilities	0	1,393	0	0	0	0	0	0	0	0	0	1,393	5
6	Maintenance	0	565	0	0	0	0	0	0	0	0	0	565	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(23,584)	2,579	0	0	0	0	0	0	0	0	0	(21,005)	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	(1,231)	0	0	0	0	0	0	0	0	0	0	(1,231)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	417	0	0	0	0	0	0	0	0	0	417	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(1,231)	417	0	0	0	0	0	0	0	0	0	(814)	16
	C. General Administration													
17	Administrative	(84,588)	23,209	198,042	0	0	0	0	0	0	0	0	136,663	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(40,000)	5,407	0	0	0	0	0	0	0	0	0	(34,593)	19
20	Fees, Subscriptions & Promotions	0	3,684	0	0	0	0	0	0	0	0	0	3,684	20
21	Clerical & General Office Expenses	0	1,511	0	0	0	0	0	0	0	0	0	1,511	21
22	Employee Benefits & Payroll Taxes	0	16,142	0	0	0	0	0	0	0	0	0	16,142	22
23	Inservice Training & Education	0	413	0	0	0	0	0	0	0	0	0	413	23
24	Travel and Seminar	0	1,289	0	0	0	0	0	0	0	0	0	1,289	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	92	0	0	0	0	0	0	0	0	0	92	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(124,588)	51,747	198,042	0	0	0	0	0	0	0	0	125,201	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(149,403)	54,743	198,042	0	0	0	0	0	0	0	0	103,382	29

STATE OF ILLINOIS

Facility Name & ID Number NAZARETHVILLE# 0021790

Report Period Beginning:

01/01/2013 Ending:

Summary B

12/31/2013

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	9,117	0	(16,787)	0	0	0	0	0	0	0	0	(7,670)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(25,354)	0	2	0	0	0	0	0	0	0	0	(25,352)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	6,847	0	0	0	0	0	0	0	0	6,847	34
35	Rent-Equipment & Vehicles	0	0	560	0	0	0	0	0	0	0	0	560	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(16,237)	0	(9,378)	0	0	0	0	0	0	0	0	(25,615)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(165,640)	54,743	188,664	0	0	0	0	0	0	0	0	77,767	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Presence Our Lady of Victory	Bourbonnais	Presence Service C	Various	Physician's Clinics
		Presence Pine View Care Center	St. Charles	Presence Fortin Vill	Bourbonnais	Childrens Center
		Presence Cor Mariae Center	Rockford	Presence Fox Knoll	Aurora	Retirement Comm
		Presence St. Joseph Center	Freeport	Presence Health	Frankfort	Parent Company
		Presence McAuley Manor	Aurora	Presence Home Cai	Various	Home Health
		Presence St. Anne Center	Rockford	Presence Care @ H	Various	Home Equipment
		Presence Villa Franciscan	Joliet	Presence Hospice	Various	Hospice

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	2 Food	\$	Presence Life Connections	100.00%	\$ 621	\$	621	1
2	V	5 Utilities		Presence Life Connections	100.00%	1,393		1,393	2
3	V	6 Maintenance - Other		Presence Life Connections	100.00%	565		565	3
4	V	11 Activities-Special Events		Presence Life Connections	100.00%	417		417	4
5	V	17 Admin - Misc. Other	145,920	Presence Life Connections	100.00%	84,200		(61,720)	5
6	V	17 Administrative Salaries		Presence Life Connections	100.00%	84,929		84,929	6
7	V	19 Professional Services		Presence Life Connections	100.00%	5,407		5,407	7
8	V	20 Dues,Subscriptions		Presence Life Connections	100.00%	3,684		3,684	8
9	V	21 Clerical Supplies		Presence Life Connections	100.00%	1,511		1,511	9
10	V	22 Employee Benefits		Presence Life Connections	100.00%	16,142		16,142	10
11	V	23 Education/Conference		Presence Life Connections	100.00%	413		413	11
12	V	24 Travel		Presence Life Connections	100.00%	1,289		1,289	12
13	V	26 Insurance		Presence Life Connections	100.00%	92		92	13
14	Total		\$ 145,920			\$ 200,663	\$ *	54,743	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	30 Depreciation	\$	Presence Life Connections	100.00%	\$ 1,030	\$ 1,030
16	V	32 Interest		Presence Life Connections	100.00%	2	2
17	V	34 Rent - Facility		Presence Life Connections	100.00%	6,847	6,847
18	V	35 Rent - Equipment		Presence Life Connections	100.00%	560	560
19	V	17 Admin Salaries		Presence Health	100.00%	99,393	99,393
20	V	30 Depreciation	31,673	Presence Health	100.00%	13,856	(17,817)
21	V	17 Admin Consulting, Other	339,590	Presence Health	100.00%	438,239	98,649
22	V	39 Ancillary Services - Other	188,223	Presence Senior Services Pharmacy	100.00%	188,223	
23	V						
24	V						
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		\$ 559,486			\$ 748,150	\$ * 188,664

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

Facility Name & ID Number

NAZARETHVILLE

0021790

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Presence Heritage Village	Kankakee	Presence Hospitals	Various	Hospital	1
2			Presence Ballard Nursing Center	Des Plaines	Laverna Terrace Housin	Avilla, IN	Independent Living	2
3			Presence Maryhaven Nursing & Rehab Center	Glenview	Presence Heritage Lodg	Kankakee	Supportive Living	3
4			Presence Nazarethville	Des Plaines	Presence Life Connectic	Mokena	Management Compat	4
5			Presence Resurrection Life Center	Chicago	Presence Senior Service	Kankakee	Pharmacy	5
6			Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence St. Joseph Adu	Freeport	Adult Day Care	6
7			Presence St Andrew Life Center	Niles	Presence Heritage Day I	Kankakee	Adult Day Care	7
8			Presence St Benedict Nursing & Rehab Center	Niles	Presence St. Vincent	Freeport	Community Living	8
9			Presence Villa Scalabrini Nursing & Rehab Cen	Northlake	Presence Behavioral He	Broadview	Parent	9
10					Presence Holy Family	Des Plaines	Hospital	10
11					Presence Bethlehem W	LaGrange Park	Independent Living	11
12					Presence Our Lady of	Chicago	Hospital	12
13					Presence Casa San Ca	Northlake	Independent Living	13
14					Presence Ambulatory	Various	Parent	14
15					Resurrection Developr	Chicago	Parent	15
16					Presence Healthcare S	Various	Parent	16
17					Presence Health Care	Various	Physicians	17
18					Presence Home Care S	Various	Home Health	18
19					Presence Resurrection	Chicago	Hospital	19
20					Resurrection Ministries of New York		Nursing Home	20
21					Resurrection Services	Des Plaines	Parent	21
22					Presence Saint Francis	Evanston	Hospital	22
23					Presence Saint Joseph	Chicago	Hospital	23
24					Presence Saints Mary	Chicago	Hospital	24
25					Resurrection Retireme	Chicago	Independent Living	25
26					Resurrection Universit	Chicago	College	26
27					Presence Health Partn	Various	Parent	27
28					Presence Properties PI	Frankfort	Parent	28
29					Presence Ventures, Inc	Frankfort	Parent	29
30					Presence Heritage Est	Kankakee	Independent Living	30

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	JO-ANN COSTANTINO	BOD						1
2	NANCY T. DOWD	BOD						2
3	FLORIDA FREEMAN	BOD						3
4	PATRICIA GOMEZ	BOD						4
5	JAMES C. HAGEN	BOD						5
6	LUCIA JONES	BOD						6
7	TERESA (TESS) KWIATKOWSKI	BOD						7
8	CONNIE S. MARCH	BOD						8
9	SR. MARIE MASON	BOD						9
10	SALLIE MILLER	BOD						10
11	PHYLLIS NICHOLS	BOD						11
12	LAWRENCE R. PANKAU	BOD						12
13	PAUL SKIEM	BOD						13
14	THOMAS E. SMITH	BOD						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

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	2	3	4	5	6		7		8	9
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	N/A							\$		1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13							TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number NAZARETHVILLE

0021790 Report Period Beginning: 01/01/2013

Ending: 2/31/2013

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 Presence Life Connections
 Street Address 18927 Hickory Creek Dr, Ste 300
 City / State / Zip Code Mokena, IL 60448
 Phone Number (708)478-7900
 Fax Number (708)478-5387

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	2	Food	Management Fee Income 7,173,919	29	\$ 30,538		145,920	\$ 621	1
2	5	Utilities	Management Fee Income 7,173,919	29	68,461		145,920	1,393	2
3	6	Maintenance - Other	Management Fee Income 7,173,919	29	27,769		145,920	565	3
4	11	Activities-Special Events	Management Fee Income 7,173,919	29	20,505		145,920	417	4
5	17	Admin - Misc. Other	Management Fee Income 7,173,919	29	4,139,560		145,920	84,200	5
6	17	Administrative Salaries	Management Fee Income 7,173,919	29	4,175,380	4,175,380	145,920	84,929	6
7	19	Professional Services	Management Fee Income 7,173,919	29	265,828		145,920	5,407	7
8	20	Dues,Subscriptions	Management Fee Income 7,173,919	29	181,120		145,920	3,684	8
9	21	Clerical Supplies	Management Fee Income 7,173,919	29	74,289		145,920	1,511	9
10	22	Employee Benefits	Management Fee Income 7,173,919	29	793,578		145,920	16,142	10
11	23	Education/Conference	Management Fee Income 7,173,919	29	20,317		145,920	413	11
12	24	Travel	Management Fee Income 7,173,919	29	63,365		145,920	1,289	12
13	26	Insurance	Management Fee Income 7,173,919	29	4,528		145,920	92	13
14	30	Depreciation	Management Fee Income 7,173,919	29	50,634		145,920	1,030	14
15	32	Interest	Management Fee Income 7,173,919	29	87		145,920	2	15
16	34	Rent - Facility	Management Fee Income 7,173,919	29	336,621		145,920	6,847	16
17	35	Rent - Equipment	Management Fee Income 7,173,919	29	27,511		145,920	560	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 10,280,091	\$ 4,175,380		\$ 209,102	25

Facility Name & ID Number NAZARETHVILLE

0021790 Report Period Beginning: 01/01/2013

Ending: 2/31/2013

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 Presence Health
 Street Address 100 North River Road
 City / State / Zip Code Des Plaines, IL 60016
 Phone Number (815)806-2327
 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	17	Admin Salaries	Operating Expense	6,637,889	8	\$ 1,942,819	\$ 1,942,819	339,590	\$ 99,393	1
2	30	Depreciation	Operating Expense	704,065	8	308,000		31,673	13,856	2
3	17	Admin Consulting,Other	Operating Expense	6,637,889	8	8,566,162		339,590	438,239	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					\$ 10,816,981	\$ 1,942,819		\$ 551,488	25

Facility Name & ID Number NAZARETHVILLE

0021790 Report Period Beginning: 01/01/2013

Ending: 2/31/2013

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 Presence Senior Services Pharmacy
 Street Address 100 North River Road
 City / State / Zip Code DesPlaines, IL 60016
 Phone Number (847-410-4900
 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	39	Ancillary Services - Other	Direct Allocation		\$	\$		\$ 188,223	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				\$	\$		\$ 188,223	25

Facility Name & ID Number

NAZARETHVILLE

0021790

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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	Home Office Allocation						\$	\$			\$ 2 1					
2											2					
3											3					
4											4					
5											5					
	Working Capital															
6											6					
7											7					
8											8					
9	TOTAL Facility Related						\$	\$			\$ 2 9					
	B. Non-Facility Related*															
10											10					
11											11					
12											12					
13											13					
14	TOTAL Non-Facility Related						\$	\$			\$ 14					
15	TOTALS (line 9+line14)						\$	\$			\$ 2 15					

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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 2012 report.		\$			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.)		\$			2	
3. Under or (over) accrual (line 2 minus line 1).		\$			3	
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			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.		\$			7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2008 _____	8	FOR BHF USE ONLY			
	2009 _____	9				
	2010 _____	10			13 FROM R. E. TAX STATEMENT FOR 2012 \$	13
	2011 _____	11			14 PLUS APPEAL COST FROM LINE 5 \$	14
	2012 _____	12			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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME NAZARETHVILLE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0021790

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>_____</u>	\$ <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 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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).

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home			\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number NAZARETHVILLE

0021790

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	83				\$	\$		\$	\$	\$
5										
6										
7										
8										
	Improvement Type**									
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

*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 NAZARETHVILLE

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 233,271	\$ 41,804	\$ 41,804	\$	6	\$ 171,288	71
72	Current Year Purchases	156,452	9,117	18,234	9,117	11	9,117	72
73	Fully Depreciated Assets	358,823				6	354,910	73
74	Home Office Allocation		14,886	14,886				74
75	TOTALS	\$ 748,546	\$ 65,807	\$ 74,924	\$ 9,117		\$ 535,315	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	PLANT ENGINEERING	1988 GMC TRUCK	1988	\$ 14,922	\$	\$	\$	7	\$ 14,922	76
77	PLANT ENGINEERING	1993 FORD VAN	1993	15,500				7	15,500	77
78	PLANT ENGINEERING	2000 BUICK LESABRE	2000	18,075				4	18,075	78
79	PLANT ENGINEERING	2007 DODGE CAR	2007	20,545				5	19,518	79
80	TOTALS			\$ 69,042	\$	\$	\$		\$ 68,015	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)	\$ 817,588	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 65,807	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 74,924	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,117	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 603,330	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Home Office Allocation				6,847			5
6								6
7	TOTAL				\$ 6,847			7

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 2,525 Description: Nursing \$742, Administration \$1123, Activities \$50, Plant Operations \$50, Home Office \$560

(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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 3	# of prescrpts				188,223		188,223	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	188,223		\$ 188,223	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 **NAZARETHVILLE**# **0021790**Report Period Beginning: **01/01/2013**

Ending:

12/31/2013**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2013**

(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	\$ 1,529	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	567,655		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,254		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 573,438	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,179		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	890,714		16
17	Accumulated Depreciation (book methods)	(603,330)		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 (spec <u>Deferred Comp</u>)			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 288,563	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 862,001	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 48,375	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	97,054		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Related Party</u>	1,865,906		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,011,335	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Conditional Asset Retirement</u>			43
44	<u>Deferred Lease Payable</u>			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,011,335	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,149,334)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 862,001	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (685,040)	1
2	Restatements (describe):		2
3	Prior Year Audit Adjustments	30,976	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (654,064)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(495,270)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (495,270)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,149,334)	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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,738,145	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,738,145	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	88	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 88	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		13
14	Non-Patient Meals	2,198	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	209,193	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,231	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	21,386	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 234,008	23
D. Non-Operating Revenue			
24	Contributions	71	24
25	Interest and Other Investment Income***	25,354	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 25,425	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates		28
28a	Other Misc Income	23,786	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 23,786	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,021,452	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,430,749	31
32	Health Care	2,093,946	32
33	General Administration	1,566,841	33
B. Capital Expense			
34	Ownership	95,176	34
C. Ancillary Expense			
35	Special Cost Centers	188,223	35
36	Provider Participation Fee	141,787	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,516,722	40
41	Income before Income Taxes (line 30 minus line 40)**	(495,270)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (495,270)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,330,133	44
45	Private Pay - Net Inpatient Revenue	3,408,012	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Insurance</u>		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,738,145	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

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

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

Facility Name & ID Number NAZARETHVILLE

0021790

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

12/31/2013

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,841	2,046	\$ 87,836	\$ 42.93	1
2	Assistant Director of Nursing					2
3	Registered Nurses	19,691	21,726	699,249	32.18	3
4	Licensed Practical Nurses	4,707	5,368	138,971	25.89	4
5	CNAs & Orderlies	54,053	60,541	890,015	14.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,786	1,998	31,139	15.59	9
10	Activity Assistants	6,842	7,676	97,484	12.70	10
11	Social Service Workers	1,829	2,069	32,841	15.87	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,349	4,886	134,133	27.45	17
18	Housekeepers	10,350	12,102	158,738	13.12	18
19	Laundry	4,615	5,145	52,340	10.17	19
20	Administrator	1,656	2,052	95,381	46.48	20
21	Assistant Administrator					21
22	Other Administrative	5,084	5,627	77,766	13.82	22
23	Office Manager	668	707	14,097	19.94	23
24	Clerical	1,731	1,998	41,509	20.78	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	47	47	3,449	73.38	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Admissions					32
33	Other(specify) <u>Pastoral Care</u>	1,891	2,193	39,367	17.95	33
34	TOTAL (lines 1 - 33)	121,140	136,181	\$ 2,594,315 *	\$ 19.05	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	\$		35	
36	Medical Director	Monthly 2,009	9,3	36	
37	Medical Records Consultant			37	
38	Nurse Consultant			38	
39	Pharmacist Consultant			39	
40	Physical Therapy Consultant			40	
41	Occupational Therapy Consultant			41	
42	Respiratory Therapy Consultant			42	
43	Speech Therapy Consultant			43	
44	Activity Consultant			44	
45	Social Service Consultant	14	980	12,3	45
46	Other(specify)			46	
47				47	
48				48	
49	TOTAL (lines 35 - 48)	14	\$ 2,989		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
Sr Lucille Madura/Sr Elizabeth Trem	Administrator		\$ 95,381	Workers' Compensation Insurance	\$ 44,524	IDPH License Fee	\$		
Administrative Staff	Office Manager		14,097	Unemployment Compensation Insurance	8,732	Advertising: Employee Recruitment			
Administrative Staff	Department Heads		5,165	FICA Taxes	190,198	Health Care Worker Background Check			
Administrative Staff	Receptionists		40,567	Employee Health Insurance	342,302	(Indicate # of checks performed <u>19</u>)			
Administrative Staff	Medical Director		3,449	Employee Meals		Patient Background Checks	<u>26</u>		
Administrative Staff	Administrative Asst		32,034	Illinois Municipal Retirement Fund (IMRF)*		Employee Recruitment			
				Dental	9,780	Dues & Subscription	7,662		
TOTAL (agree to Schedule V, line 17, col. 1)				Life Insurance	(1,748)	Advertisiosg & Public Relations			
(List each licensed administrator separately.)			\$ 190,693	Disability Insurance	19,535				
B. Administrative - Other				Pension	163,581	Home Office Allocation	3,684		
Description			Amount	Tuition Reimbursement	9,680	Less: Public Relations Expense	()		
Corp Office Management Fee			\$ 485,510	Other Benefits	3,815	Non-allowable advertising	()		
				Home Office Allocation	16,142	Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 485,510	TOTAL (agree to Schedule V, line 22, col.8)		\$ 806,541	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 11,346
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type		Amount						
Legal	Various		\$ 42,332	N/A		\$	Out-of-State Travel	\$	
Survey & Analytical Tools	Various		3,887						
							In-State Travel	521	
							Seminar Expense		
							Home Office Allocation	1,289	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 46,219				TOTAL	\$ 1,810	

* Attach copy of IMRF notifications

**See instructions.

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 NAZARETHVILLE

0021790

Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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. Life Services Network \$4838
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,440 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 141,787
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? YES Indicate the amount. \$ 2,198
- (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? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG
- (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.