

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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.

I. IDPH License ID Number: 0051102

Facility Name: Litchfield Care Center

Address: 1024 East Tyler Litchfield 62056
Number City Zip Code

County: Montgomery

Telephone Number: (217)324-3842 Fax # (217)324-3842

HFS ID Number:

Date of Initial License for Current Owners: 09/01/10

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Steve Lavenda Telephone Number: (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/11 to 12/31/11 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) Cary C. Buxbaum, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center

0051102 Report Period Beginning: 01/01/11 Ending: 12/31/11

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	65	Intermediate (ICF)	65	23,725	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	65	TOTALS	65	23,725	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	21,676	996	14	22,686	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,676	996	14	22,686	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.62%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by the Department? None (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 9/1/2010

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 9/1/2010 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 N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number Litchfield Care Center # 0051102 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	121,949	12,784	4,651	139,384		139,384	(68)	139,316			1
2	Food Purchase		100,368		100,368		100,368	(44)	100,324			2
3	Housekeeping	60,205	9,874		70,079		70,079		70,079			3
4	Laundry	31,883	4,486	1,404	37,773		37,773		37,773			4
5	Heat and Other Utilities			61,526	61,526		61,526	161	61,687			5
6	Maintenance	53,523	15,427	16,768	85,718		85,718	5,370	91,088			6
7	Other (specify):*							612	612			7
8	TOTAL General Services	267,560	142,939	84,349	494,848		494,848	6,031	500,879			8
	B. Health Care and Programs											
9	Medical Director			5,500	5,500		5,500		5,500			9
10	Nursing and Medical Records	662,229	20,878	5,721	688,828		688,828	16,442	705,270			10
10a	Therapy	238			238		238		238			10a
11	Activities	35,939	1,892	2,740	40,571		40,571		40,571			11
12	Social Services			8,486	8,486		8,486		8,486			12
13	CNA Training											13
14	Program Transportation							1,324	1,324			14
15	Other (specify):*							2,570	2,570			15
16	TOTAL Health Care and Programs	698,406	22,770	22,447	743,623		743,623	20,336	763,959			16
	C. General Administration											
17	Administrative	83,197		14,999	98,196		98,196	11,093	109,289			17
18	Directors Fees											18
19	Professional Services			100,541	100,541		100,541	(74,520)	26,021			19
20	Dues, Fees, Subscriptions & Promotions			15,340	15,340		15,340	(2,802)	12,538			20
21	Clerical & General Office Expenses	53,702	1,765	25,495	80,962		80,962	31,060	112,022			21
22	Employee Benefits & Payroll Taxes			164,597	164,597		164,597		164,597			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,461	1,461		1,461	(326)	1,135			24
25	Other Admin. Staff Transportation			7,449	7,449		7,449	1,209	8,658			25
26	Insurance-Prop.Liab.Malpractice			23,874	23,874		23,874	730	24,604			26
27	Other (specify):*							9,203	9,203			27
28	TOTAL General Administration	136,899	1,765	353,756	492,420		492,420	(24,353)	468,067			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,102,865	167,474	460,552	1,730,891		1,730,891	2,014	1,732,905			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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			24,156	24,156		24,156	12,947	37,103			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,244	12,244		12,244	59,905	72,149			32
33	Real Estate Taxes			22,054	22,054		22,054	841	22,895			33
34	Rent-Facility & Grounds			127,000	127,000		127,000	(127,000)				34
35	Rent-Equipment & Vehicles			2,927	2,927		2,927	2,985	5,912			35
36	Other (specify):*											36
37	TOTAL Ownership			188,381	188,381		188,381	(50,322)	138,059			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			35,588	35,588		35,588		35,588			42
43	Other (specify):*			58,861	58,861		58,861	(58,861)				43
44	TOTAL Special Cost Centers			94,449	94,449		94,449	(58,861)	35,588			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,102,865	167,474	743,382	2,013,721		2,013,721	(107,169)	1,906,552			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(364)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(69,154)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(44)	02		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	(500)	21		18
19	Entertainment	(810)	24		19
20	Contributions	(2,500)	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	(2,395)	21		24
25	Fund Raising, Advertising and Promotional	(580)	20		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	(56,458)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (132,806)		\$	30

BHF USE ONLY							
48		49		50		51	
						52	

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

		1 Amount	2 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)	25,637		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 25,637		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (107,169)		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 Yes	2 No	3 Amount	4 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

Litchfield Care Center

ID# 0051102

Report Period Beginning: 01/01/11

Ending: 12/31/11

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Bank Charges	\$ (550)	21	1
2	Non-Allowable Legal	(6,753)	19	2
3	Prior Period Real Estate Tax	(163)	33	3
4	Additional R&M	4,477	06	4
5	Non-Allowable Expense	(53,470)	43	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	(56,458)		49

Litchfield Care Center

	ID#	0051102
Report Period Beginning:		01/01/11
Ending:		12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Litchfield Care Center # 0051102 Report Period Beginning: 01/01/11 Ending: 12/31/11

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				(68)								(68)	1
2	Food Purchase	(44)											(44)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(364)		525									161	5
6	Maintenance	4,477		893									5,370	6
7	Other (specify):*			63	549								612	7
8	TOTAL General Services	4,069		1,481	481								6,031	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				16,442								16,442	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation				1,324								1,324	14
15	Other (specify):*				2,570								2,570	15
16	TOTAL Health Care and Programs				20,336								20,336	16
	C. General Administration													
17	Administrative			12,323	(1,230)								11,093	17
18	Directors Fees													18
19	Professional Services	(6,753)		(68,166)	220	179							(74,520)	19
20	Fees, Subscriptions & Promotions	(3,080)		227	29	22							(2,802)	20
21	Clerical & General Office Expenses	(3,445)		30,768	3,702	35							31,060	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(810)		351	133								(326)	24
25	Other Admin. Staff Transportation			1,019	190								1,209	25
26	Insurance-Prop.Liab.Malpractice			730									730	26
27	Other (specify):*			8,156	1,047								9,203	27
28	TOTAL General Administration	(14,088)		(14,592)	4,091	236							(24,353)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(10,019)		(13,111)	24,908	236							2,014	29

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
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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	Rent Income	\$ 114,250	Centralia Property, LLC	100.00%	\$	(114,250)	1
2	V	32	Interest Expense		Centralia Property, LLC	100.00%	57,967	57,967	2
3	V	30	Depreciation		Centralia Property, LLC	100.00%	79,724	79,724	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 114,250			\$ 137,691	\$ * 23,441	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	5	UTILITIES	\$	YAM MANAGEMENT, LLC	100.00%	\$ 525	\$ 525	15
16	V	6	REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	893	893	16
17	V	7	EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	63	63	17
18	V	17	ADMINISTRATIVE		YAM MANAGEMENT, LLC	100.00%	12,323	12,323	18
19	V	19	PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	920	920	19
20	V	20	FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	227	227	20
21	V	21	CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	30,768	30,768	21
22	V	24	SEMINARS		YAM MANAGEMENT, LLC	100.00%	351	351	22
23	V	25	AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	1,019	1,019	23
24	V	26	INSURANCE		YAM MANAGEMENT, LLC	100.00%	730	730	24
25	V	27	EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	8,156	8,156	25
26	V	30	DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	574	574	26
27	V	32	INTEREST		YAM MANAGEMENT, LLC	100.00%	35	35	27
28	V	33	REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%	1,604	1,604	28
29	V	34	RENT		YAM MANAGEMENT, LLC	100.00%	5,389	5,389	29
30	V	35	AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	625	625	30
31	V	35	EQUIPMENT RENTAL		YAM MANAGEMENT, LLC	100.00%	221	221	31
32	V								32
33	V								33
34	V	19	DATA PROCESSING	278	YAM MANAGEMENT, LLC	100.00%		(278)	34
35	V	19	BOOKKEEPING FEES	56,808	YAM MANAGEMENT, LLC	100.00%		(56,808)	35
36	V	19	ACCOUNTING	12,000	YAM MANAGEMENT, LLC	100.00%		(12,000)	36
37	V	34	RENT	12,750	YAM MANAGEMENT, LLC	100.00%		(12,750)	37
38	V								38
39	Total			\$ 81,836			\$ 64,423	\$ * (17,413)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	1	DIETARY	\$	YAM CONSULTING, LLC	100.00%	\$ 4,583	\$ 4,583	15
16	V	7	EMP. BEN. GEN. SERV.		YAM CONSULTING, LLC	100.00%	549	549	16
17	V	10	NURSING SALARY		YAM CONSULTING, LLC	100.00%	20,642	20,642	17
18	V	14	PROGRAM TRANSPORTATION		YAM CONSULTING, LLC	100.00%	1,324	1,324	18
19	V	15	EMP. BEN. HEALTHCARE		YAM CONSULTING, LLC	100.00%	2,570	2,570	19
20	V	17	ADMINISTRATIVE		YAM CONSULTING, LLC	100.00%	6,770	6,770	20
21	V	19	PROFESSIONAL FEES		YAM CONSULTING, LLC	100.00%	1,795	1,795	21
22	V	20	FEES, SUBSCRIPTIONS		YAM CONSULTING, LLC	100.00%	29	29	22
23	V	21	CLERICAL & GENERAL		YAM CONSULTING, LLC	100.00%	3,702	3,702	23
24	V	24	SEMINARS		YAM CONSULTING, LLC	100.00%	133	133	24
25	V	25	AUTO AND TRAVEL		YAM CONSULTING, LLC	100.00%	190	190	25
26	V	27	EMP. BEN.-GEN. ADMIN.		YAM CONSULTING, LLC	100.00%	1,047	1,047	26
27	V	30	DEPRECIATION		YAM CONSULTING, LLC	100.00%	23	23	27
28	V	35	AUTO RENTAL		YAM CONSULTING, LLC	100.00%	2,139	2,139	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	01	DIETICIAN CONSULTING	4,651	YAM CONSULTING, LLC	100.00%		(4,651)	33
34	V	10	NURSE CONSULTING	4,200	YAM CONSULTING, LLC	100.00%		(4,200)	34
35	V	17	DIR. OF OPERATIONS CONSULT	8,000	YAM CONSULTING, LLC	100.00%		(8,000)	35
36	V	19	DATA PROCESSING FEES	1,575	YAM CONSULTING, LLC	100.00%		(1,575)	36
37	V	43	MARKETING	5,391	YAM CONSULTING, LLC	100.00%		(5,391)	37
38	V								38
39	Total			\$ 23,817			\$ 45,496	\$ * 21,679	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.

YESNO

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	19	PROFESSIONAL FEES	\$	8131 N. MONTICELLO, LLC	100.00%	\$ 179	\$ 179	15
16	V	20	DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		22	22	16
17	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		35	35	17
18	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		1,780	1,780	18
19	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		1,903	1,903	19
20	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		1,004	1,004	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	5,389	8131 N. MONTICELLO, LLC			(5,389)	26
27	V	33	REAL ESTATE TAXES	1,604	8131 N. MONTICELLO, LLC			(1,604)	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			\$ 6,993			\$ 4,923	\$ * (2,070)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.

YESNO

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			\$			\$	\$	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			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			\$			\$	\$	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			\$			\$	\$ *	39

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			\$			\$	\$	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			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			\$			\$	\$	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			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			\$			\$	\$	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			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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			\$			\$	\$	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			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	ML EQUITY PARTNERS LLC	5.000%	BERKSHIRE NURSING & REHAB CENTER,LLC	FOREST PARK	YAM MANAGEMENT	SKOKIE	MANAGEMENT CO.	1
2	MARTIN LOEB	2.000%	CONCORD NURSING AND REHABILITATION CENTER,LLC	OAK LAWN	YAM CONSULTING	SKOKIE	CONSULTING CO.	2
3	HOWARD SUSS	5.000%	DOLTON NURSING & REHAB,LLC	DOLTON	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDIN	3
4	DAVID BERKOWITZ	36.500%	EVANSTON NURSING & REHAB CENTER, LLC	EVANSTON	CENTRALIA PROPERTY, LLC	SKOKIE	BUILDING CO.	4
5	DECLARATION OF TRUST OF YOSEF MEYSTEL	34.500%	EXCEPTIONAL CARE, LLC	BURBANK				5
6	JAY MEYSTEL TRUST	4.000%	FAIRVIEW CARE CENTER OF JOLIET,LLC	JOLIET				6
7	STEVEN TUROFSKY	1.000%	HIGHLAND PARK NURSING AND REHAB CENTER, LLC	HIGHWOOD				7
8	FREDERICK S. FRANKEL	1.000%	INTERNATIONAL NURSING & REHAB CENTER,LLC	CHICAGO				8
9	CHRISTINA INOFRE	1.000%	JACKSONVILLE CARE CENTER	JACKSONVILLE				9
10	42170 LIMITED PARTNERSHIP	2.500%	NORTH CHURCH NURSING & REHAB,LLC	JACKSONVILLE				10
11	1219 LIMITED PARTNERSHIP	2.500%	PLAZA NURSING AND REHAB CENTER,LLC	MIDLOTHIAN				11
12	906 LLC	2.500%	PLUM GROVE NURSING AND REHAB,LLC	PALATINE				12
13	CONGREGATION OF TIFERES AVROHOM	2.500%	RIVIERA CARE CENTER,LLC	CHICAGO HEIGHTS				13
14			ROCKFORD NUR. & REHAB	ROCKFORD				14
15			SPRINGFIELD CARE CENTER,LLC	SPRINGFIELD				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

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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Litchfield Care Center # 0051102 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	Yosef Meystel	Relative	Administrative	0.00%	See Attached	1.4	3.50%	Consult. Fees	\$ 3,000	17-3	1
2	David Berkowitz	Owner	Administrative	36.50%	See Attached	1.4	3.50%	Consult. Fees	4,000	17-3	2
3	Joel Meystel	Relative	Administrative	N/A	See Attached	0.7	3.50%	Alloc. Salary	796	17-7	3
4	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.7	1.75%	Alloc. Salary	2,090	17-7	4
5	Fred Frankel	Owner	Administrative	1.00%	See Attached	1.4	3.50%	Alloc. Salary	4,916	17-7	5
6	Steve Turofsky	Owner	Administrative	1.00%	See Attached	1.4	3.50%	Alloc. Salary	3,845	17-7	6
7	Christina Inofre	Owner	Nursing	1.00%	See Attached	1.4	3.50%	Alloc. Salary	3,680	10-07	7
8											8
9	Where applicable, the amounts reported on this page have been adjusted from the actual costs to										9
10	reflect only amounts anticipated to be considered allowable by the Illinois Department of HFS.										10
11											11
12											12
13								TOTAL	\$ 22,327		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center # 0051102 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

Ending: 12/31/11

(847) 673-6768

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center # 0051102 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 YAM CONSULTING, LLC
Street Address 8131 N. MONTICELLO
City / State / Zip Code SKOKIE, ILLINOIS 60076
Phone Number (847) 673-6767
Fax Number (847) 673-6768

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	1	DIETARY	AVAIL. BED DAYS	686,836	17	\$ 132,684	\$ 123,698	23,725	\$ 4,583	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	686,836	17	15,896		23,725	549	2
3	10	NURSING SALARY	AVAIL. BED DAYS	686,836	17	597,577	597,577	23,725	20,642	3
4	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	686,836	17	38,325		23,725	1,324	4
5	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	686,836	17	74,394		23,725	2,570	5
6	17	ADMINISTRATIVE	AVAIL. BED DAYS	686,836	17	195,987	195,987	23,725	6,770	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	51,975		23,725	1,795	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	849		23,725	29	8
9	21	CLERICAL & GENERAL	AVAIL. BED DAYS	686,836	17	107,160	91,547	23,725	3,702	9
10	24	SEMINARS	AVAIL. BED DAYS	686,836	17	3,858		23,725	133	10
11	25	AUTO AND TRAVEL	AVAIL. BED DAYS	686,836	17	5,508		23,725	190	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	686,836	17	30,309		23,725	1,047	12
13	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	673		23,725	23	13
14	35	AUTO RENTAL	AVAIL. BED DAYS	686,836	17	61,921		23,725	2,139	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,317,116	\$ 1,008,809		\$ 45,496	25

Facility Name & ID Number Litchfield Care Center # 0051102 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 8131 N. MONTICELLO, LLC
Street Address 8131 N. MONTICELLO
City / State / Zip Code SKOKIE, ILLINOIS 60076
Phone Number (847) 673-6767
Fax Number (847) 673-6768

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	\$ 5,168	\$	20,440	\$ 179	1
2	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	624		20,440	22	2
3	21	OFFICE EXPENSE	AVAIL. BED DAYS	686,836	17	1,000		20,440	35	3
4	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	51,542		20,440	1,780	4
5	32	INTEREST EXPENSE	AVAIL. BED DAYS	686,836	17	55,103		20,440	1,903	5
6	33	REAL ESTATE TAXES	AVAIL. BED DAYS	686,836	17	29,058		20,440	1,004	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					\$ 142,495	\$		\$ 4,923	25

Facility Name & ID Number Litchfield Care Center # 0051102 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

Facility Name & ID Number Litchfield Care Center # 0051102 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Litchfield Care Center # 0051102 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Litchfield Care Center # 0051102 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

Facility Name & ID Number Litchfield Care Center # 0051102 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

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

Facility Name & ID Number Litchfield Care Center # 0051102 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
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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	
	Name of Lender	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	Bank Financial		X	Mortgage			\$	1,003,631			\$ 57,967	1	
2	Ford Credit		X	Auto Loan				3,988	2/15/2012	3.9000		2	
3												3	
4												4	
5	See Supplemental Schedule											5	
	Working Capital												
6	Bank Financial		X	Line of Credit				329,033			11,525	6	
7	Assurance		X	Insurance Financing							719	7	
8	See Supplemental Schedule											8	
9	TOTAL Facility Related						\$	1,336,652			\$ 70,211	9	
	B. Non-Facility Related*												
10	YAM Management Allocation	X									35	10	
11	8131 N. Monticello Allocation	X									1,903	11	
12												12	
13	See Supplemental Schedule											13	
14	TOTAL Non-Facility Related						\$				\$ 1,938	14	
15	TOTALS (line 9+line14)						\$	1,336,652			\$ 72,149	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 - SUPPLEMENTAL SCHEDULE

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	
	Name of Lender	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							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8							\$	\$			\$	8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital											14	
	B. Non-Facility Related*												
15							\$	\$			\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

FACILITY NAME	<u>Litchfield Care Center</u>	COUNTY	<u>Montgomery</u>
FACILITY IDPH LICENSE NUMBER	<u>0051102</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Steve Lavenda</u>		
TELEPHONE	<u>(847) 236-1111</u>	FAX #:	<u>(847) 236-1155</u>

Enter the tax index number and real estate tax assessed for 2010 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 2010.

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? X 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.)

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

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 2010 report.				\$	21,891	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.)				\$	22,895	2
3. Under or (over) accrual (line 2 minus line 1).				\$	1,004	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	21,891	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.				\$	22,895	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2006		8		
		2007		9		
		2008		10		
		2009		11		
		2010	21,891	12		
2011 Accrual = 2010 Tax (Rounded)						
8131 N. Monticello Allocation = \$1,004						
Beginning Accrual Adjusted						

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$	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

SEE ACCOUNTANTS' COMPILATION REPORT

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Litchfield Care Center</u>	COUNTY	<u>Montgomery</u>
---------------	-------------------------------	--------	-------------------

FACILITY IDPH LICENSE NUMBER 0051102

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 2000 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 2000.

(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		\$	\$

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?

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

B. General Construction Type:

Exterior Brick

Frame Wood

Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒ YES

☐ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2010	\$ 8,241	1
2	Home Office		2010	3,074	2
3	TOTALS			\$ 11,315	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	65		2010	1971	\$ 666,776	\$ 9,229	20	\$ 19,051	\$ 9,822	\$ 25,401	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

*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

Facility Name & ID Number Litchfield Care Center

0051102

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
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	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		35,725	1,894		1,261	(633)	1,861	68
69	Financial Statement Depreciation			24,155			(24,155)		69
70	TOTAL (lines 4 thru 69)		\$ 702,501	\$ 35,278		\$ 20,312	\$ (14,966)	\$ 27,262	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Litchfield Care Center

0051102

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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		\$ 702,501	\$ 35,278		\$ 20,312	\$ (14,966)	\$ 27,262	1
2	Dry Pipe Valve	2011	3,825		20	383	383	383	2
3	New Canopy	2011	5,250		20	306	306	306	3
4	Security Camera System	2011	6,074		20	911	911	911	4
5	New Roof Including Soffitt, Fascia, And Gutter System	2011	59,675		20				5
6	Remove And Replace Windows And Screen	2011	65,664		20				6
7	Remove Rooftop A/C Unit, Replace With Ground Units	2011	19,554		20				7
8	Drywall-Laundry Rm, Break Rm & Closet Ceilings, Behind Old P	2011	5,000		20				8
9	4 Outside Outlets, 6 Outside Lights, Remove Old Antenna	2011	2,940		20				9
10	New Landscaping, 17Ft Fence, Flag Pole	2011	6,350		20				10
11	Remove & Replace Concrete At Front Door	2011	5,500		20				11
12	Garage-New Siding, Roof & Door	2011	4,200		20				12
13	Office-New P-Tech Units, Drywall, Wiring & Siding	2011	3,530		20				13
14	Cabinets & Counter Top-Break Rm, Nurse Station, Mop Room &	2011	5,500		20				14
15	West Side-Remove & Replace Concrete	2011	4,100		20				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	TOTAL (lines 1 thru 33)		\$ 899,663	\$ 35,278		\$ 21,912	\$ (13,366)	\$ 28,862	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
1 Totals from Page 12B, Carried Forward		\$ 899,663	\$ 35,278		\$ 21,912	\$ (13,366)	\$ 28,862	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 899,663	\$ 35,278		\$ 21,912	\$ (13,366)	\$ 28,862	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 12C, Carried Forward		\$ 899,663	\$ 35,278		\$ 21,912	\$ (13,366)	\$ 28,862	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 899,663	\$ 35,278		\$ 21,912	\$ (13,366)	\$ 28,862	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
1	Totals from Page 12D, Carried Forward		\$899,663	\$35,278		\$21,912	\$(13,366)	\$28,862	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$899,663	\$35,278		\$21,912	\$(13,366)	\$28,862	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
1	Building Company Information							1
2	Buildings:							2
3								3
4								4
5								5
6								6
7								7
8	Leasehold Improvements:							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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	
1	Building Company Information Continued		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		\$	\$		\$	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Litchfield Care Center

0051102

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 8131 N. Monticello	2010	23,887	710	20	612	(98)	893	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from 8131 N. Monticello	2010	10,700	1,070	20	535	(535)	823	9
10	Allocated from YAM Management	2010	1,138	114	20	114		145	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. Building and Improvement Costs-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	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 35,725	\$ 1,894		\$ 1,261	\$ (633)	\$ 1,861	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$82,245	\$70,871	\$13,303	\$(57,568)	10	\$18,143	71
72	Current Year Purchases	92	4	4		10	4	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$82,337	\$70,875	\$13,307	\$(57,568)		\$18,147	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		2007 Ford E350- Purchased New	2011	\$16,615	\$	\$1,780	\$1,780	5	\$1,780	76
77		YAM MANAGEMENT, LLC	2009	929	103	103		5	35	77
78										78
79										79
80	TOTALS			\$17,544	\$103	\$1,883	\$1,780		\$1,815	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$1,010,859	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$106,256	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$37,102	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(69,154)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$48,824	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: 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.

		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?
16. Rental Amount for movable equipment: \$ 3,148
- Description: See Attached Schedule

(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	Allocated from YAM Management			625	18
19	Allocated from YAM Consulting			2,139	19
20					20
21	TOTAL		\$	\$ 2,764	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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		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)	\$			

- (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.

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	

- (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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	2	3	4		6	7	8	
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	N/A	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental									13
14	TOTAL			\$		\$	\$		\$	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,471	\$ 3,174	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	423,945	423,945	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,728	31,728	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	183,322	335,880	8
9	Other(specify): See Attached Schedule	27,829	527,478	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 668,295	\$ 1,322,205	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		182,918	13
14	Buildings, at Historical Cost		330,516	14
15	Leasehold Improvements, at Historical Cost	192,988	222,403	15
16	Equipment, at Historical Cost	50,456	239,281	16
17	Accumulated Depreciation (book methods)	(26,424)	(121,428)	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): See Attached Schedule	487,782	487,782	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 704,802	\$ 1,341,472	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,373,097	\$ 2,663,677	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 83,024	\$ 83,025	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,563	2,563	28
29	Short-Term Notes Payable	333,021	333,021	29
30	Accrued Salaries Payable	110,705	110,705	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,327	2,327	31
32	Accrued Real Estate Taxes(Sch.IX-B)	21,891	21,891	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	774,787	774,787	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,328,318	\$ 1,328,319	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,003,631	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule		240,343	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,243,974	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,328,318	\$ 2,572,293	46
47	TOTAL EQUITY(page 18, line 24)	\$ 44,779	\$ 91,384	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,373,097	\$ 2,663,677	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 21,105	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 21,105	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	40,341	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	(16,667)	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)	\$ 23,674	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)	\$ 44,779	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,051,218	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,051,218	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,844	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,844	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,054,062	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	494,848	31
32	Health Care	743,623	32
33	General Administration	492,420	33
	B. Capital Expense		
34	Ownership	188,381	34
	C. Ancillary Expense		
35	Special Cost Centers	58,861	35
36	Provider Participation Fee	35,588	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,013,721	40
41	Income before Income Taxes (line 30 minus line 40)**	40,341	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 40,341	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

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	2,017	2,123	\$ 60,344	\$ 28.43	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,692	7,463	178,066	23.86	3
4	Licensed Practical Nurses	6,007	6,634	120,341	18.14	4
5	CNAs & Orderlies	20,835	22,783	254,029	11.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	20	21	238	11.15	8
9	Activity Director					9
10	Activity Assistants	2,450	2,643	35,939	13.60	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,073	2,309	27,408	11.87	14
15	Cook Helpers/Assistants	7,567	8,053	94,541	11.74	15
16	Dishwashers					16
17	Maintenance Workers	3,807	3,965	53,523	13.50	17
18	Housekeepers	4,657	5,124	60,205	11.75	18
19	Laundry	2,720	2,963	31,883	10.76	19
20	Administrator	1,855	2,061	83,197	40.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,812	2,053	53,702	26.16	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	1,949	2,107	49,449	23.47	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	64,460	70,301	\$ 1,102,865 *	\$ 15.69	34

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	80	\$ 4,651	01-03	35
36	Medical Director	Monthly	5,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	75	4,200	10-03	38
39	Pharmacist Consultant	25	1,521	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	50	2,740	11-03	44
45	Social Service Consultant	50	2,486	12-03	45
46	Other(specify)				46
47	Psychiatric M.D.	Monthly	6,000	12-03	47
48					48
49	TOTAL (lines 35 - 48)	280	\$ 27,098		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

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Barbara Lowry	Administrator	0%	\$ 83,197
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 83,197
B. Administrative - Other			
Description			Amount
Administrative Consulting - YAM Consulting			\$ 8,000
Management Fees - Yosef Meystel			3,000
Management Fees - David Berkowitz			4,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 15,000
C. Professional Services			
Vendor/Payee	Type		Amount
Frost Ruttenberg & Rothblatt, P.C.	Accounting		\$ 2,825
ADAR	Data Processing		279
Health Data Systems, Inc.	Data Processing		2,914
Legal	See Attached		8,925
PAS Management, Ltd.	Property Advisory		13,433
YAM Consulting	Data Processing		1,575
YAM Management	Data Processing		278
YAM Management	Accounting		12,000
YAM Management	Bookkeeping		56,808
Prospect Resources, Inc.	Energy Consultants		360
Personnel Planners, Inc.	Unemployment Consultant		784
MTS Consulting, LLC	Tax Consulting		360
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 100,541
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 34,720
Unemployment Compensation Insurance			15,945
FICA Taxes			82,327
Employee Health Insurance			30,933
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Benefits - Other			672
TOTAL (agree to Schedule V, line 22, col.8)			\$ 164,598
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			
Health Care Worker Background Check (Indicate # of checks performed <u>57</u>)			574
Patient Background Checks			
Dues & Subscriptions			8,453
License and Permits			3,233
Allocated from YAM Management			227
Allocated from YAM Consulting			29
Allocated from 8131 N. Monticello			22
Less: Public Relations Expense		(	
Non-allowable advertising		(	
Yellow page advertising		(	
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 12,537
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			651
Allocated from YAM Management			351
Allocated from YAM Consulting			133
Entertainment Expense		(	
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 1,135

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT**

****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	Amount of Expense Amortized Per Year								
					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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union?

Yes
- (2) Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

ICLTC \$8,229
- (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?

10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$0

Line

N/A
- (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.

\$35,588

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.

\$

No

Has any meal income been offset against related costs?

Indicate the amount.

\$N/A
- (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?

100% 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?

No

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.

\$No
- (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 out of Schedule V?

Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

N/A

Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT