

		FOR BHF USE					

LL1

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: <u>0050484</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Plum Grove Nursing And Rehab., Llc</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>24 S. Plum Grove Road</u> <u>Palatine</u> <u>60067</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(847)358-0311</u> Fax # <u>(847)358-8875</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Cary C. Buxbaum, C.P.A.</u></td></tr><tr><td>(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) <u>Cary C. Buxbaum, C.P.A.</u>	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>												
Officer or Administrator of Provider	(Signed) _____																								
	(Type or Print Name) _____																								
	(Title) _____																								
	(Signed) _____																								
Paid Preparer	(Date) _____																								
	(Print Name and Title) <u>Cary C. Buxbaum, C.P.A.</u>																								
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>																								
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>																								
Date of Initial License for Current Owners: <u>03/01/09</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
☐ Charitable Corp.	☐ Individual	☐ State																							
☐ Trust	☐ Partnership	☐ County																							
IRS Exemption Code _____	☐ Corporation	☐ Other _____																							
	☐ "Sub-S" Corp.	_____																							
	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		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																							
Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plum Grove Nursing And Rehab., Llc

0050484 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	69	Skilled (SNF)	69	25,185	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	69	TOTALS	69	25,185	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	12,938	4,760	3,767	21,465	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,938	4,760	3,767	21,465	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.23%

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

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 X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES NO X

I. On what date did you start providing long term care at this location? Date started 8/1/2006

J. Was the facility purchased or leased after January 1, 1978? YES X Date 8/1/2006 NO

K. Was the facility certified for Medicare during the reporting year? YES X NO If YES, enter number of beds certified 69 and days of care provided 2,003

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL X MODIFIED CASH* CASH*

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number Plum Grove Nursing And Rehab., Llc # 0050484 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	140,005	12,268	10,450	162,723		162,723	(5,585)	157,138			1
2	Food Purchase		97,849		97,849	(12,136)	85,713	(217)	85,496			2
3	Housekeeping	94,279	12,679		106,958		106,958		106,958			3
4	Laundry	10,033	7,819		17,852		17,852		17,852			4
5	Heat and Other Utilities			57,348	57,348		57,348	558	57,906			5
6	Maintenance	52,043	6,245	61,432	119,720		119,720	4,606	124,326			6
7	Other (specify):*							650	650			7
8	TOTAL General Services	296,360	136,860	129,230	562,450	(12,136)	550,314	12	550,326			8
	B. Health Care and Programs											
9	Medical Director			12,750	12,750		12,750		12,750			9
10	Nursing and Medical Records	1,197,426	66,697	36,112	1,300,235		1,300,235	(11,388)	1,288,847			10
10a	Therapy	25,322			25,322		25,322		25,322			10a
11	Activities	61,035	3,943	2,436	67,414		67,414		67,414			11
12	Social Services	47,172		900	48,072		48,072		48,072			12
13	CNA Training											13
14	Program Transportation							1,405	1,405			14
15	Other (specify):*							2,728	2,728			15
16	TOTAL Health Care and Programs	1,330,955	70,640	52,198	1,453,793		1,453,793	(7,255)	1,446,538			16
	C. General Administration											
17	Administrative	95,029		37,850	132,879		132,879	8,417	141,296			17
18	Directors Fees											18
19	Professional Services			181,894	181,894	(685)	181,209	(106,288)	74,921			19
20	Dues, Fees, Subscriptions & Promotions			38,668	38,668		38,668	(14,498)	24,170			20
21	Clerical & General Office Expenses	27,270	165	130,201	157,636		157,636	(68,391)	89,245			21
22	Employee Benefits & Payroll Taxes			325,155	325,155	12,136	337,291		337,291			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,805	8,805		8,805	618	9,423			24
25	Other Admin. Staff Transportation			365	365		365	1,284	1,649			25
26	Insurance-Prop.Liab.Malpractice			57,223	57,223		57,223	775	57,998			26
27	Other (specify):*							9,769	9,769			27
28	TOTAL General Administration	122,299	165	780,161	902,625	11,451	914,076	(168,315)	745,762			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,749,614	207,665	961,589	2,918,868	(685)	2,918,183	(175,557)	2,742,626			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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			75,015	75,015		75,015	65,939	140,954			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,128	18,128		18,128	183,894	202,022			32
33	Real Estate Taxes			143,020	143,020	685	143,705	1,065	144,770			33
34	Rent-Facility & Grounds			301,000	301,000		301,000	(301,000)				34
35	Rent-Equipment & Vehicles			4,090	4,090		4,090	1,179	5,269			35
36	Other (specify):*			417	417		417		417			36
37	TOTAL Ownership			541,670	541,670	685	542,355	(48,923)	493,432			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		91,635	202,215	293,850		293,850		293,850			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,778	37,778		37,778		37,778			42
43	Other (specify):*			207,151	207,151		207,151	(207,151)				43
44	TOTAL Special Cost Centers		91,635	447,144	538,779		538,779	(207,151)	331,628			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,749,614	299,300	1,950,403	3,999,317		3,999,317	(431,631)	3,567,686			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	(3,333)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,954	30		9
10	Interest and Other Investment Income	(120)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(217)	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				18
19	Entertainment	(3,469)	21		19
20	Contributions	(11,280)	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	(73,590)	21		24
25	Fund Raising, Advertising and Promotional	(68)	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	(255,462)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (344,584)		\$	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)	(87,047)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (87,047)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (431,631)		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

Report Period Beginning:

Ending:

ID#0050484

01/01/11

12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Contributions	\$ (1,750)	20	1
2	COPE Dues	(1,695)	20	2
3	Bank Charges	(16,853)	21	3
4	Marketing Fees	(23,777)	43	4
5	Additional R&M	6,991	06	5
6	Non-Allowable Legal Expense	(3,463)	19	6
7	Non-Allowable Fees Expense	(169,124)	43	7
8	Building Company Rent Expense	(500)	34	8
9	Other Income	(6,043)	21	9
10	State Replacement Tax	(3,640)	21	10
11	2011 Seminar	105	24	11
12	Theft & Damage Loss	(1,423)	21	12
13	Non-Allowable Auto Lease	(1,990)	35	13
14	Out of Period Professional Fee	(2,100)	19	14
15	Building Company-Bank Charges	(60)	21	15
16	Building Company-Professional Fees	(3,893)	19	16
17	Building Company- Amortization	(25,721)	31	17
18	Building Company - Licenses	(525)	20	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	(255,462)		49

ID#0050484

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

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 6-Supplemental		See 6-Supplemental		See 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	Rental Income	\$ 288,000	Plum Grove Realty		\$	\$ (288,000)	1
2	V	32	Interest Income	59	Plum Grove Realty			(59)	2
3	V	34	Rent Expense		Plum Grove Realty		500	500	3
4	V	32	Interest Expense		Plum Grove Realty		182,015	182,015	4
5	V	33	Real Estate Taxes		Plum Grove Realty		143,020	143,020	5
6	V	30	Depreciation		Plum Grove Realty		60,461	60,461	6
7	V	33	Real Estate Tax Income	143,020	Plum Grove Realty			(143,020)	7
8	V	21	Bank Charges		Plum Grove Realty		60	60	8
9	V	19	Professional Fees		Plum Grove Realty		3,893	3,893	9
10	V	31	Amortization		Plum Grove Realty		25,721	25,721	10
11	V	20	Licenses and Permits		Plum Grove Realty		525	525	11
12	V								12
13	V								13
14	Total			\$ 431,079			\$ 416,195	\$ * (14,884)	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%	\$ 558	\$ 558	15
16	V	6	REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	948	948	16
17	V	7	EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	67	67	17
18	V	17	ADMINISTRATIVE		YAM MANAGEMENT, LLC	100.00%	13,081	13,081	18
19	V	19	PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	977	977	19
20	V	20	FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	241	241	20
21	V	21	CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	32,661	32,661	21
22	V	24	SEMINARS		YAM MANAGEMENT, LLC	100.00%	372	372	22
23	V	25	AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	1,082	1,082	23
24	V	26	INSURANCE		YAM MANAGEMENT, LLC	100.00%	775	775	24
25	V	27	EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	8,658	8,658	25
26	V	30	DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	609	609	26
27	V	32	INTEREST		YAM MANAGEMENT, LLC	100.00%	37	37	27
28	V	33	REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%	1,702	1,702	28
29	V	34	RENT		YAM MANAGEMENT, LLC	100.00%	5,720	5,720	29
30	V	35	AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	663	663	30
31	V	35	EQUIPMENT RENTAL		YAM MANAGEMENT, LLC	100.00%	235	235	31
32	V				YAM MANAGEMENT, LLC	100.00%			32
33	V								33
34	V	19	DATA PROCESSING	918	YAM MANAGEMENT, LLC	100.00%		(918)	34
35	V	19	BOOKKEEPING FEES	59,664	YAM MANAGEMENT, LLC	100.00%		(59,664)	35
36	V	19	ACCOUNTING	36,000	YAM MANAGEMENT, LLC	100.00%		(36,000)	36
37	V	34	RENT	13,000	YAM MANAGEMENT, LLC	100.00%		(13,000)	37
38	V	19	OTHER PROFESSIONAL	1,000	YAM MANAGEMENT, LLC	100.00%		(1,000)	38
39	Total			\$ 110,582			\$ 68,386	\$ * (42,196)	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%	\$ 4,865	\$ 4,865	15
16	V	7	EMP. BEN. GEN. SERV.		YAM CONSULTING, LLC	100.00%	583	583	16
17	V	10	NURSING SALARY		YAM CONSULTING, LLC	100.00%	21,912	21,912	17
18	V	14	PROGRAM TRANSPORTATION		YAM CONSULTING, LLC	100.00%	1,405	1,405	18
19	V	15	EMP. BEN. HEALTHCARE		YAM CONSULTING, LLC	100.00%	2,728	2,728	19
20	V	17	ADMINISTRATIVE		YAM CONSULTING, LLC	100.00%	7,186	7,186	20
21	V	19	PROFESSIONAL FEES		YAM CONSULTING, LLC	100.00%	1,906	1,906	21
22	V	20	FEES, SUBSCRIPTIONS		YAM CONSULTING, LLC	100.00%	31	31	22
23	V	21	CLERICAL & GENERAL		YAM CONSULTING, LLC	100.00%	3,929	3,929	23
24	V	24	SEMINARS		YAM CONSULTING, LLC	100.00%	141	141	24
25	V	25	AUTO AND TRAVEL		YAM CONSULTING, LLC	100.00%	202	202	25
26	V	27	EMP. BEN.-GEN. ADMIN.		YAM CONSULTING, LLC	100.00%	1,111	1,111	26
27	V	30	DEPRECIATION		YAM CONSULTING, LLC	100.00%	25	25	27
28	V	35	AUTO RENTAL		YAM CONSULTING, LLC	100.00%	2,271	2,271	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	1	DIETICIAN CONSULTING	10,450	YAM CONSULTING, LLC	100.00%		(10,450)	33
34	V	10	NURSE CONSULTING	33,300	YAM CONSULTING, LLC	100.00%		(33,300)	34
35	V	17	DIR. OF OPERATIONS CONSULT	11,850	YAM CONSULTING, LLC	100.00%		(11,850)	35
36	V	19	DATA PROCESSING FEES	6,216	YAM CONSULTING, LLC	100.00%		(6,216)	36
37	V	43	MARKETING	14,250	YAM CONSULTING, LLC	100.00%		(14,250)	37
38	V								38
39	Total			\$ 76,066			\$ 48,295	\$ * (27,771)	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	19	PROFESSIONAL FEES	\$	8131 N. MONTICELLO, LLC	100.00%	\$ 190	\$ 190	15
16	V	20	DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC	100.00%	23	23	16
17	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC	100.00%	37	37	17
18	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC	100.00%	1,890	1,890	18
19	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC	100.00%	2,021	2,021	19
20	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC	100.00%	1,065	1,065	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	5,720	8131 N. MONTICELLO, LLC	100.00%		(5,720)	26
27	V	33	REAL ESTATE TAXES	1,702	8131 N. MONTICELLO, LLC	100.00%		(1,702)	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			\$ 7,422			\$ 5,226	\$ * (2,196)	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

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

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

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	DAVID BERKOWITZ	30.000%	BERKSHIRE NURSING & REHAB CENTER,LLC	FOREST PARK	PLUM GROVE REALTY, LLC	SKOKIE	BUILDING CO.	1
2	MORRIS ESFORMES	40.000%	CONCORD NURSING AND REHABILITATION CENTER,LLC	OAK LAWN	YAM MANAGEMENT	SKOKIE	MANAGEMENT CO.	2
3	YOSEF MEYSEL	30.000%	DOLTON NURSING & REHAB,LLC	DOLTON	YAM CONSULTING	SKOKIE	CONSULTING CO.	3
4			EVANSTON NURSING & REHAB CENTER, LLC	EVANSTON	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDIN	4
5			EXCEPTIONAL CARE, LLC	BURBANK				5
6			FAIRVIEW CARE CENTER OF JOLIET,LLC	JOLIET				6
7			HIGHLAND PARK NURSING AND REHAB CENTER, LLC	HIGHWOOD				7
8			INTERNATIONAL NURSING & REHAB CENTER,LLC	CHICAGO				8
9			JACKSONVILLE CARE CENTER	JACKSONVILLE				9
10			LITCHFIELD CARE CENTER,LLC	LITCHFIELD				10
11			NORTH CHURCH NURSING & REHAB,LLC	JACKSONVILLE				11
12			PLAZA NURSING AND REHAB CENTER,LLC	MIDLOTHIAN				12
13			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 Plum Grove Nursing And Rehab., Llc # 0050484 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	Shareholder	Administrative	30.00%	See Attached	1.5	3.75%	Mgmt Fees	\$ 9,000	17-3	1
2	David Berkowitz	Shareholder	Administrative	30.00%	See Attached	1.5	3.75%	Mgmt Fees	14,000	17-3	2
3	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.7	1.75%	Alloc. Salary	2,218	17-7	3
4	Joel Meystel	Relative	Administrative	0.00%	See Attached	0.7	3.50%	Alloc. Salary	845	17-7	4
5											5
6											6
7											7
8											8
9											9
10	Where applicable, the amounts reported on this page have been adjusted from the acutal costs to reflect only amounts anticipated to be considered allowable										10
11	by the Il. Dept of HFS.										11
12											12
13								TOTAL	\$ 26,063		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 Plum Grove Nursing And Rehab., Llc # 0050484 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 X
- 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 Plum Grove Nursing And Rehab., Llc # 0050484 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 MANAGEMENT, 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	5	UTILITIES	AVAIL. BED DAYS	686,836	17	\$ 15,204	\$	25,185	\$ 558	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	686,836	17	25,846	8,238	25,185	948	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	686,836	17	1,829		25,185	67	3
4	17	ADMINISTRATIVE	AVAIL. BED DAYS	686,836	17	356,736	356,736	25,185	13,081	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	26,635		25,185	977	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	6,564		25,185	241	6
7	21	CLERICAL & GENERAL	AVAIL. BED DAYS	686,836	17	890,719	835,933	25,185	32,661	7
8	24	SEMINARS	AVAIL. BED DAYS	686,836	17	10,148		25,185	372	8
9	25	AUTO AND TRAVEL	AVAIL. BED DAYS	686,836	17	29,510		25,185	1,082	9
10	26	INSURANCE	AVAIL. BED DAYS	686,836	17	21,145		25,185	775	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	686,836	17	236,117		25,185	8,658	11
12	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	16,611		25,185	609	12
13	32	INTEREST	AVAIL. BED DAYS	686,836	17	1,006		25,185	37	13
14	33	REAL ESTATE TAX	AVAIL. BED DAYS	686,836	17	46,424		25,185	1,702	14
15	34	RENT	AVAIL. BED DAYS	686,836	17	156,000		25,185	5,720	15
16	35	AUTO RENTAL	AVAIL. BED DAYS	686,836	17	18,091		25,185	663	16
17	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	686,836	17	6,400		25,185	235	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,864,985	\$ 1,200,907		\$ 68,386	25

Facility Name & ID Number Plum Grove Nursing And Rehab., Llc # 0050484 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	25,185	\$ 4,865	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	686,836	17	15,896		25,185	583	2
3	10	NURSING SALARY	AVAIL. BED DAYS	686,836	17	597,577	597,577	25,185	21,912	3
4	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	686,836	17	38,325		25,185	1,405	4
5	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	686,836	17	74,394		25,185	2,728	5
6	17	ADMINISTRATIVE	AVAIL. BED DAYS	686,836	17	195,987	195,987	25,185	7,186	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	51,975		25,185	1,906	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	849		25,185	31	8
9	21	CLERICAL & GENERAL	AVAIL. BED DAYS	686,836	17	107,160	91,547	25,185	3,929	9
10	24	SEMINARS	AVAIL. BED DAYS	686,836	17	3,858		25,185	141	10
11	25	AUTO AND TRAVEL	AVAIL. BED DAYS	686,836	17	5,508		25,185	202	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	686,836	17	30,309		25,185	1,111	12
13	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	673		25,185	25	13
14	35	AUTO RENTAL	AVAIL. BED DAYS	686,836	17	61,921		25,185	2,271	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		\$ 48,295	25

Facility Name & ID Number Plum Grove Nursing And Rehab., Llc # 0050484 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 X 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	\$ 190	1
2	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	624		20,440	23	2
3	21	OFFICE EXPENSE	AVAIL. BED DAYS	686,836	17	1,000		20,440	37	3
4	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	51,542		20,440	1,890	4
5	32	INTEREST EXPENSE	AVAIL. BED DAYS	686,836	17	55,103		20,440	2,021	5
6	33	REAL ESTATE TAXES	AVAIL. BED DAYS	686,836	17	29,058		20,440	1,065	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	\$		\$ 5,226	25

Facility Name & ID Number Plum Grove Nursing And Rehab., Llc # 0050484 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 X 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		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
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 Plum Grove Nursing And Rehab., Llc # 0050484 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 Plum Grove Nursing And Rehab., Llc # 0050484 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 Plum Grove Nursing And Rehab., Llc # 0050484 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 Plum Grove Nursing And Rehab., Llc # 0050484 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

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

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

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

Facility Name & ID Number Plum Grove Nursing And Rehab., Llc # 0050484 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

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	Plum Grove Realty		X	Mortgage			\$	2,600,000			\$	182,015	1	
2													2	
3													3	
4													4	
5	See Supplemental Schedule												5	
	Working Capital													
6	First Equity Bank		X	Line of Credit				542,223				17,192	6	
7	First Equity Bank		X	Insurance Financing				16,720				936	7	
8	See Supplemental Schedule							592,046					8	
9	TOTAL Facility Related						\$	3,750,989			\$	200,143	9	
	B. Non-Facility Related*													
10	Interest Income		X									(120)	10	
11	Building Co Interest Income											(59)	11	
12	Allocated from YAM Management		X									37	12	
13	See Supplemental Schedule											2,021	13	
14	TOTAL Non-Facility Related						\$				\$	1,879	14	
15	TOTALS (line 9+line14)							\$	3,750,989			\$	202,022	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				Note Payable			\$		\$ 92,046			\$	8
9	Private Bank		X	Note Payable					500,000				9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital								592,046				14
	B. Non-Facility Related*												
15	Allocated from 8131 N. Monticello		X				\$		\$			\$ 2,021	15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related											2,021	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.)

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.		\$	118,158	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.)		\$	131,654	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	13,496	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	130,589	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.		\$	685	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.		\$	144,770	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006		8	
		2007		9	
		2008	106,829	10	
		2009	118,158	11	
		2010	130,589	12	
2011 Accrual based on the 2010 tax bill without inflation.					
Allocated from 8131 N. Monticello- \$1,065					

		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

FACILITY NAME	<u>Plum Grove Nursing And Rehab., Llc</u>	COUNTY	<u>Cook</u>
FACILITY IDPH LICENSE NUMBER	<u>0050484</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Steve Lavenda</u>		
TELEPHONE	(847) 236-1111	FAX #:	(847) 236-1155

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.

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.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Plum Grove Nursing And Rehab., Llc</u>	COUNTY	<u>Cook</u>
---------------	---	--------	-------------

FACILITY IDPH LICENSE NUMBER 0050484

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:

23,500

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

2

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		2009	\$ 120,000	1
2	Allocated from 8131 N. Monticello			3,263	2
3	TOTALS			\$ 123,263	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					\$	\$		\$	\$	\$	4
5	69			1961	1,927,220	60,461	35	55,063	(5,398)	137,761	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

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	Related Building Company (Pages 12F & 12G)							67
68	Related Party Allocations (Pages 12H & 12I)	37,924	2,011		1,339	(672)	1,976	68
69	Financial Statement Depreciation		50,632			(50,632)		69
70	TOTAL (lines 4 thru 69)	\$ 1,965,144	\$ 113,104		\$ 56,402	\$ (56,702)	\$ 139,737	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Plum Grove Nursing And Rehab., Llc

0050484

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		\$ 1,965,144	\$ 113,104		\$ 56,402	\$ (56,702)	\$ 139,737	1
2	Fire Sprinkler	2009	125,779		20	6,289	6,289	18,867	2
3	Door Alarm	2009	6,447		20	322	322	967	3
4	Fire Alarm	2009	12,068		20	603	603	1,810	4
5	Shunt Trip For Elevator	2009	3,800		20	190	190	570	5
6	Outside Wiring With Molding	2009	3,920		20	196	196	588	6
7	Elevator Shunt Relay & Supervisory Relay	2009	2,786		20	139	139	418	7
8	Existing Floor Removal, Installation Of New Flooring, Light Fixtu	2009	27,718		20	1,386	1,386	4,158	8
9	Headend Hardware & Installation	2010	3,700		20	185	185	370	9
10	Wiring / Cabling For Rooms	2010	8,250		20	413	413	825	10
11	1St Flr Corridor-Wall Coverings,Handrails,Bumpers,Endcaps,Va	2010	18,913		20	1,273	1,273	2,545	11
12	1St Flr Corridor-Handrails, Bumpers	2010	5,530		20	276	276	553	12
13	Existing Wallpaper Removal-Main Lobby,W Stairwell,Lower Lvl	2010	24,567		20	1,228	1,228	2,457	13
14	Guest Bathrooms,Lover Level Corridor-Wall Coverings,Handrail	2010	10,515		20	526	526	1,052	14
15	Patio Enclosure Renovation	2011	232,506		20	11,625	11,625	11,625	15
16	Fire Dampers	2011	19,000		20	950	950	950	16
17	Boiler Room Ceiling Work	2011	3,648		20	182	182	182	17
18	Elevator Car Door Panels	2011	4,720		20	236	236	236	18
19	Handrails, Wallcovering, Flooring	2011	45,643		20	2,282	2,282	2,282	19
20	Patio Enclosure - Floor Reinforcement	2011	38,800		20	2,040	2,040	2,040	20
21	Window Covering, Flooring, Wallcovering, Chair Rail, Lighting	2011	29,501		20	1,475	1,475	1,475	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)		\$ 2,592,956	\$ 113,104		\$ 88,220	\$ (24,884)	\$ 193,707	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 12B, Carried Forward		\$ 2,592,956	\$ 113,104		\$ 88,220	\$ (24,884)	\$ 193,707	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)		\$ 2,592,956	\$ 113,104		\$ 88,220	\$ (24,884)	\$ 193,707	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		\$ 2,592,956	\$ 113,104		\$ 88,220	\$ (24,884)	\$ 193,707	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)		\$ 2,592,956	\$ 113,104		\$ 88,220	\$ (24,884)	\$ 193,707	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 12D, Carried Forward		\$ 2,592,956	\$ 113,104		\$ 88,220	\$ (24,884)	\$ 193,707	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)		\$ 2,592,956	\$ 113,104		\$ 88,220	\$ (24,884)	\$ 193,707	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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34								34

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.

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	25,357	754	39	650	(104)	948	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from YAM Management	2010	1,208	121	20	121		154	9
10	Allocated from 8131 N. Monticello	2010	11,359	1,136	20	568	(568)	874	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	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)		\$37,924	\$2,011		\$1,339	\$(672)	\$1,976	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	\$49,595	\$400	\$4,655	\$4,255	10	\$9,703	71
72	Current Year Purchases	384,397	14,850	38,434	23,584	10	2,153	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$433,992	\$15,250	\$43,089	\$27,839		\$11,856	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		2009 GMC Savana	2009	\$47,683	\$9,537	\$9,537	\$(0)	5	\$28,610	76
77		Allocated from YAM Managemer	2011	986	109	109		5	37	77
78										78
79										79
80	TOTALS			\$48,669	\$9,646	\$9,646	\$(0)		\$28,647	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)	\$3,198,880	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$138,000	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$140,954	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$2,954	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$234,211	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.
- ☐ YES
- ☐ NO

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

**

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

This amount was calculated by dividing the total amount to be amortized
by the length of the lease

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO

16. Rental Amount for movable equipment: \$ 2,335
- 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	Allocated from YAM Management		\$	\$ 663	17
18	Allocated from YAM Consulting			2,271	18
19					19
20					20
21	TOTAL		\$	\$ 2,934	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.

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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		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)	\$			

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 93,190	\$		\$ 93,190	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			16,462			16,462	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			92,563			92,563	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				87,708		87,708	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						3,927		3,927	13
14	TOTAL			\$		\$ 202,215	\$ 91,635		\$ 293,850	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	\$ 1,000	\$ 86,698	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,006,760	1,006,760	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	37,934	37,934	6
7	Other Prepaid Expenses	553	553	7
8	Accounts Receivable (owners or related parties)	265,200	2,022,323	8
9	Other(specify): See Attached Schedule	185,250	217,928	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,496,697	\$ 3,372,196	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		114,800	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	670,939	1,638,159	15
16	Equipment, at Historical Cost	106,938	469,746	16
17	Accumulated Depreciation (book methods)	(128,523)	(304,868)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(25,721)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	962,083	1,076,539	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,611,437	\$ 2,968,655	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,108,134	\$ 6,340,851	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 398,172	\$ 398,171	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	87,648	87,648	28
29	Short-Term Notes Payable	650,989	650,989	29
30	Accrued Salaries Payable	69,446	69,446	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,539	22,539	31
32	Accrued Real Estate Taxes(Sch.IX-B)	130,589	130,589	32
33	Accrued Interest Payable	3,571	4,755	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,365,737	1,466,684	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,728,691	\$ 2,830,821	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,100,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 3,100,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,728,691	\$ 5,930,821	46
47	TOTAL EQUITY(page 18, line 24)	\$ 379,443	\$ 410,030	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,108,134	\$ 6,340,851	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 247,888	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 247,888	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	241,555	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	(110,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 131,555	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)	\$ 379,443	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	\$ 3,336,949	1
2	Discounts and Allowances for all Levels	128,870	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,465,819	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	670,741	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 670,741	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	82,649	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,445	19
20	Radiology and X-Ray	1,320	20
21	Other Medical Services	4,735	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 98,149	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	120	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 120	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	6,043	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,043	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,240,872	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	562,450	31
32	Health Care	1,453,793	32
33	General Administration	902,625	33
	B. Capital Expense		
34	Ownership	541,670	34
	C. Ancillary Expense		
35	Special Cost Centers	501,001	35
36	Provider Participation Fee	37,778	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,999,317	40
41	Income before Income Taxes (line 30 minus line 40)**	241,555	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 241,555	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	1,965	2,086	\$ 71,404	\$ 34.23	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,961	6,295	178,381	28.34	3
4	Licensed Practical Nurses	11,596	12,456	315,349	25.32	4
5	CNAs & Orderlies	40,330	43,390	567,113	13.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,801	1,937	25,322	13.07	8
9	Activity Director					9
10	Activity Assistants	4,024	4,399	61,035	13.87	10
11	Social Service Workers	1,925	2,086	47,172	22.61	11
12	Dietician					12
13	Food Service Supervisor	1,929	2,077	40,443	19.47	13
14	Head Cook	3,477	3,710	43,598	11.75	14
15	Cook Helpers/Assistants	5,427	5,635	55,964	9.93	15
16	Dishwashers					16
17	Maintenance Workers	2,133	2,270	52,043	22.93	17
18	Housekeepers	8,638	9,049	94,279	10.42	18
19	Laundry	899	1,015	10,033	9.88	19
20	Administrator	2,080	2,454	95,029	38.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,921	2,086	27,270	13.07	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	1,923	2,086	65,179	31.25	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	96,029	103,031	\$ 1,749,614 *	\$ 16.98	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	209	\$ 10,450	01-03	35
36	Medical Director	Monthly	12,750	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	666	33,300	10-03	38
39	Pharmacist Consultant	562	2,812	10-03	39
40	Physical Therapy Consultant	Montly			40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	49	2,436	11-03	44
45	Social Service Consultant	18	900	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,504	\$ 62,648		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.

Facility Name & ID Number		Plum Grove Nursing And Rehab., Llc		STATE OF ILLINOIS		Report Period Beginning:		01/01/11		Page 21		Ending:		12/31/11			
XIX. SUPPORT SCHEDULES																	
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions									
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount							
Lisa Ulbert		Administrator	0.00%	\$ 95,029	Workers' Compensation Insurance		\$ 54,287	IDPH License Fee		\$ 3,980							
					Unemployment Compensation Insurance		58,254	Advertising: Employee Recruitment		665							
					FICA Taxes		132,521	Health Care Worker Background Check		1,228							
					Employee Health Insurance		65,143	(Indicate # of checks performed 122.8)									
					Employee Meals		12,136	Patient Background Checks									
					Illinois Municipal Retirement Fund (IMRF)*			Advertising & Promotions									
					Other Employee Benefits		1,976	Dues & Subscriptions		14,082							
					Employee Welfare		12,974	Licenses & Permits		3,920							
TOTAL (agree to Schedule V, line 17, col. 1)								Allocated from 8131 N. Monticello		23							
(List each licensed administrator separately.)				\$ 95,029				See Supplemental Schedule		272							
B. Administrative - Other								Less: Public Relations Expense		()							
Description				Amount				Non-allowable advertising		()							
YAM Consulting Director of Operations Consulting				\$ 11,850				Yellow page advertising		()							
Management Fees- David Berkowitz				14,000				TOTAL (agree to Sch. V,		\$ 24,170							
Management Fees- Yosef Meystel				9,000				line 20, col. 8)									
See Supplemetal Schedule				3,000				TOTAL (agree to Schedule V,									
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 37,850				line 22, col.8)									
(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										Out-of-State Travel		\$	
Frost, Ruttenberg & Rothblatt		Accounting		\$ 24,325													
YAM Management		Bookkeeping		59,664													
YAM Management		Accounting		36,000													
Personnel Planners		Unemployment Consulting		975										In-State Travel			
YAM Management		Data Processing		918													
YAM Consulting		Data Processing		6,216													
Health Data Systems		Data Processing		6,632													
E-Health Data		Data Processing		2,700										Seminar Expense		8,910	
ADAR		Data Processing		2,300										Allocated from YAM Management		372	
SAS Architects & Planners		Architects		4,174										Allocated from YAM Conlusting		141	
First Real Estate Services		Real Estate Appraisal		500													
See Supplemetal Schedule				37,489										Entertainment Expense		()	
TOTAL (agree to Schedule V, line 19, column 3)								TOTAL		\$				(agree to Sch. V,			
(If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 181,893										TOTAL		\$ 9,423	

* 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?

No

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

Yes

If YES, give association name and amount. ICLTC- \$5,126

(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. \$22,182 Line10

(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)? YESNOX

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. \$37,778

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. \$12,136

Has any meal income been offset against related costs?

N/A

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?

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. \$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?

Yes

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

SEE ACCOUNTANTS' COMPILATION REPORT