

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0051086</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Springfield Care Center</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>525 S. Martin Luther King Dr.</u> <u>Springfield</u> <u>62703</u>			
NumberCityZip Code			
County: <u>Sangamon</u>			
Telephone Number: <u>(217)789-1680</u> Fax # <u>(217)789-0842</u>			
HFS ID Number: _____		Officer or Administrator of Provider Paid Preparer	
Date of Initial License for Current Owners: <u>09/01/10</u>			
Type of Ownership:			
☐ VOLUNTARY,NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code _____ ☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☒ Limited Liability Co. ☐ Trust ☐ Other _____			

☐ GOVERNMENTAL☐ State☐ County☐ Other _____

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center

0051086 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	65	Intermediate (ICF)	65	23,725	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	65	TOTALS	65	23,725	7

B. Census-For the entire report period.

	1 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	20,438	463	39	20,940	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,438	463	39	20,940	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.26%

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

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 9/1/2010

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

YES ☒ Date 9/1/2010 NO ☐

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

YES ☐ NO ☒ If YES, enter number of beds certified _____ and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☐ 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 Springfield Care Center # 0051086 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	99,927	8,439	6,246	114,612		114,612	(1,663)	112,949			1
2	Food Purchase		96,531		96,531		96,531	(21)	96,510			2
3	Housekeeping	75,460	8,221		83,681		83,681		83,681			3
4	Laundry	916	2,221	3,121	6,258		6,258		6,258			4
5	Heat and Other Utilities			58,227	58,227		58,227	(670)	57,557			5
6	Maintenance	31,715	11,977	26,378	70,070		70,070	17,700	87,770			6
7	Other (specify):*							612	612			7
8	TOTAL General Services	208,018	127,389	93,972	429,379		429,379	15,958	445,337			8
	B. Health Care and Programs											
9	Medical Director			10,800	10,800		10,800		10,800			9
10	Nursing and Medical Records	674,237	24,495	21,072	719,804		719,804	844	720,648			10
10a	Therapy		11		11		11		11			10a
11	Activities	36,008	5,028	643	41,679		41,679		41,679			11
12	Social Services			6,880	6,880		6,880		6,880			12
13	CNA Training											13
14	Program Transportation			100	100		100	1,324	1,424			14
15	Other (specify):*							2,570	2,570			15
16	TOTAL Health Care and Programs	710,245	29,534	39,495	779,274		779,274	4,738	784,012			16
	C. General Administration											
17	Administrative	60,751		19,001	79,752		79,752	12,093	91,845			17
18	Directors Fees											18
19	Professional Services			80,681	80,681		80,681	(61,001)	19,680			19
20	Dues, Fees, Subscriptions & Promotions			24,073	24,073		24,073	(3,217)	20,856			20
21	Clerical & General Office Expenses	23,828	980	25,384	50,192		50,192	33,176	83,368			21
22	Employee Benefits & Payroll Taxes			177,915	177,915		177,915		177,915			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,264	2,264		2,264	(470)	1,794			24
25	Other Admin. Staff Transportation			12,823	12,823		12,823	1,209	14,032			25
26	Insurance-Prop.Liab.Malpractice			30,782	30,782		30,782	730	31,512			26
27	Other (specify):*							9,203	9,203			27
28	TOTAL General Administration	84,579	980	372,923	458,482		458,482	(8,277)	450,205			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,002,842	157,903	506,390	1,667,135		1,667,135	12,418	1,679,553			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			11,724	11,724		11,724	23,683	35,407			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,468	4,468		4,468	58,253	62,721			32
33	Real Estate Taxes			16,237	16,237		16,237	846	17,083			33
34	Rent-Facility & Grounds			127,000	127,000		127,000	(127,000)				34
35	Rent-Equipment & Vehicles			6,239	6,239		6,239	2,985	9,224			35
36	Other (specify):*											36
37	TOTAL Ownership			165,668	165,668		165,668	(41,233)	124,435			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			35,588	35,588		35,588		35,588			42
43	Other (specify):*			49,589	49,589		49,589	(49,589)				43
44	TOTAL Special Cost Centers			85,177	85,177		85,177	(49,589)	35,588			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,002,842	157,903	757,235	1,917,980		1,917,980	(78,404)	1,839,576			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	(1,195)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(56,147)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(21)	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	(954)	24		19
20	Contributions	(2,500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(436)	21		24
25	Fund Raising, Advertising and Promotional	(995)	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	(28,544)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (90,793)		\$	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)	12,389		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 12,389		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (78,404)		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

ID#

0051086

Report Period Beginning:

01/01/11

Ending:

12/31/11

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Bank Charges	\$ (893)	21	1
2	Prior Period Real Estate Tax	(158)	33	2
3	Additional R&M	16,807	06	3
4	Non-Allowable Expense	(42,336)	43	4
5	Non-Allowable Legal	(1,964)	19	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
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19				19
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41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(28,544)		49

Springfield Care Center

	ID#	0051086
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
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72				23
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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 Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	\$ 114,000	Centralia Property, LLC	100.00%	\$	(114,000)	1
2	V	30	Depreciation		Centralia Property, LLC		77,453	77,453	2
3	V	32	Interest Expense		Centralia Property, LLC		56,315	56,315	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 114,000			\$ 133,768	\$ * 19,768	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	YAM MANAGEMENT, LLC	100.00%	\$ 525	\$ 525	15
16	V	6	REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	893	893	16
17	V	7	EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	63	63	17
18	V	17	ADMINISTRATIVE		YAM MANAGEMENT, LLC	100.00%	12,323	12,323	18
19	V	19	PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	920	920	19
20	V	20	FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	227	227	20
21	V	21	CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	30,768	30,768	21
22	V	24	SEMINARS		YAM MANAGEMENT, LLC	100.00%	351	351	22
23	V	25	AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	1,019	1,019	23
24	V	26	INSURANCE		YAM MANAGEMENT, LLC	100.00%	730	730	24
25	V	27	EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	8,156	8,156	25
26	V	30	DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	574	574	26
27	V	32	INTEREST		YAM MANAGEMENT, LLC	100.00%	35	35	27
28	V	33	REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%	1,604	1,604	28
29	V	34	RENT		YAM MANAGEMENT, LLC	100.00%	5,389	5,389	29
30	V	35	AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	625	625	30
31	V	35	EQUIPMENT RENTAL		YAM MANAGEMENT, LLC	100.00%	221	221	31
32	V	0			YAM MANAGEMENT, LLC	100.00%			32
33	V								33
34	V	19	DATA PROCESSING FEES	503				(503)	34
35	V	19	BOOKKEEPING FEES	49,428	YAM MANAGEMENT, LLC	100.00%		(49,428)	35
36	V	19	ACCOUNTING	12,000	YAM MANAGEMENT, LLC	100.00%		(12,000)	36
37	V	34	RENT	13,000	YAM MANAGEMENT, LLC	100.00%		(13,000)	37
38	V								38
39	Total			\$ 74,931			\$ 64,423	\$ * (10,508)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	\$	YAM CONSULTING, LLC	100.00%	\$ 4,583	\$ 4,583	15
16	V	7	EMP. BEN. GEN. SERV.		YAM CONSULTING, LLC	100.00%	549	549	16
17	V	10	NURSING SALARY		YAM CONSULTING, LLC	100.00%	20,642	20,642	17
18	V	14	PROGRAM TRANSPORTATION		YAM CONSULTING, LLC	100.00%	1,324	1,324	18
19	V	15	EMP. BEN. HEALTHCARE		YAM CONSULTING, LLC	100.00%	2,570	2,570	19
20	V	17	ADMINISTRATIVE		YAM CONSULTING, LLC	100.00%	6,770	6,770	20
21	V	19	PROFESSIONAL FEES		YAM CONSULTING, LLC	100.00%	1,795	1,795	21
22	V	20	FEES, SUBSCRIPTIONS		YAM CONSULTING, LLC	100.00%	29	29	22
23	V	21	CLERICAL & GENERAL		YAM CONSULTING, LLC	100.00%	3,702	3,702	23
24	V	24	SEMINARS		YAM CONSULTING, LLC	100.00%	133	133	24
25	V	25	AUTO AND TRAVEL		YAM CONSULTING, LLC	100.00%	190	190	25
26	V	27	EMP. BEN.-GEN. ADMIN.		YAM CONSULTING, LLC	100.00%	1,047	1,047	26
27	V	30	DEPRECIATION		YAM CONSULTING, LLC	100.00%	23	23	27
28	V	35	AUTO RENTAL		YAM CONSULTING, LLC	100.00%	2,139	2,139	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	01	DIETICIAN CONSULTING	6,246	YAM CONSULTING, LLC	100.00%		(6,246)	33
34	V	10	NURSE CONSULTING	19,798	YAM CONSULTING, LLC	100.00%		(19,798)	34
35	V	17	DIR. OF OPERATIONS CONSULT	7,000	YAM CONSULTING, LLC	100.00%		(7,000)	35
36	V	43	MARKETING	7,253	YAM CONSULTING, LLC	100.00%		(7,253)	36
37	V								37
38	V								38
39	Total			\$ 40,297			\$ 45,496	\$ * 5,199	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%	\$ 179	\$ 179	15
16	V	20	DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		22	22	16
17	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		35	35	17
18	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		1,780	1,780	18
19	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		1,903	1,903	19
20	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		1,004	1,004	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	5,389	8131 N. MONTICELLO, LLC			(5,389)	26
27	V	33	REAL ESTATE TAXES	1,604	8131 N. MONTICELLO, LLC			(1,604)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 6,993			\$ 4,923	\$ * (2,070)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ML EQUITY PARTNERS LLC	5.000%	BERKSHIRE NURSING & REHAB CENTER,LLC	FOREST PARK	YAM MANAGEMENT	SKOKIE	MANAGEMENT CO.	1
2	MARTIN LOEB	2.000%	CONCORD NURSING AND REHABILITATION CENTER,LLC	OAK LAWN	YAM CONSULTING	SKOKIE	CONSULTING CO.	2
3	HOWARD SUSS	5.000%	DOLTON NURSING & REHAB,LLC	DOLTON	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDIN	3
4	DAVID BERKOWITZ	36.500%	EVANSTON NURSING & REHAB CENTER, LLC	EVANSTON	CENTRALIA PROPERTY, LLC	SKOKIE	BUILDING CO.	4
5	DECLARATION OF TRUST OF YOSEF MEYSTEL	34.500%	EXCEPTIONAL CARE, LLC	BURBANK				5
6	JAY MEYSTEL TRUST	4.000%	FAIRVIEW CARE CENTER OF JOLIET,LLC	JOLIET				6
7	STEVEN TUROFSKY	1.000%	HIGHLAND PARK NURSING AND REHAB CENTER, LLC	HIGHWOOD				7
8	FREDERICK S. FRANKEL	1.000%	INTERNATIONAL NURSING & REHAB CENTER,LLC	CHICAGO				8
9	CHRISTINA INOFRE	1.000%	JACKSONVILLE CARE CENTER	JACKSONVILLE				9
10	42170 LIMITED PARTNERSHIP	2.500%	LITCHFIELD CARE CENTER,LLC	LITCHFIELD				10
11	1219 LIMITED PARTNERSHIP	2.500%	NORTH CHURCH NURSING & REHAB,LLC	JACKSONVILLE				11
12	906 LLC	2.500%	PLAZA NURSING AND REHAB CENTER,LLC	MIDLOTHIAN				12
13	CONGREGATION OF TIFERES AVROHOM	2.500%	PLUM GROVE NURSING AND REHAB,LLC	PALATINE				13
14			RIVIERA CARE CENTER,LLC	CHICAGO HEIGHTS				14
15			ROCKFORD NUR. & REHAB	ROCKFORD				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 Springfield Care Center # 0051086 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Relative	Administrative	0.00%	See Attached	1.4	3.50%	Consult. Fees	\$ 2,000	17-3	1
2	David Berkowitz	Owner	Administrative	36.50%	See Attached	1.4	3.50%	Consult. Fees	4,000	17-3	2
3	Joel Meystel	Relative	Administrative	N/A	See Attached	0.7	3.50%	Alloc. Salary	796	17-7	3
4	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.7	1.75%	Alloc. Salary	2,090	17-7	4
5	Fred Frankel	Owner	Administrative	1.00%	See Attached	1.4	3.50%	Alloc. Salary	4,916	17-7	5
6	Steve Turofsky	Owner	Administrative	1.00%	See Attached	1.4	3.50%	Alloc. Salary	3,845	17-7	6
7	Christina Inofre	Owner	Nursing	1.00%	See Attached	1.4	3.50%	Alloc. Salary	3,680	10-7	7
8											8
9	Where applicable, the amounts reported on this page have been adjusted from the actual costs to										9
10	reflect only amounts anticipated to be considered allowable by the Illinois Department of HFS.										10
11											11
12											12
13								TOTAL	\$ 21,327		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center # 0051086 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 Springfield Care Center # 0051086 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	\$	23,725	\$ 525	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	686,836	17	25,846	8,238	23,725	893	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	686,836	17	1,829		23,725	63	3
4	17	ADMINISTRATIVE	AVAIL. BED DAYS	686,836	17	356,736	356,736	23,725	12,323	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	26,635		23,725	920	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	6,564		23,725	227	6
7	21	CLERICAL & GENERAL	AVAIL. BED DAYS	686,836	17	890,719	835,933	23,725	30,768	7
8	24	SEMINARS	AVAIL. BED DAYS	686,836	17	10,148		23,725	351	8
9	25	AUTO AND TRAVEL	AVAIL. BED DAYS	686,836	17	29,510		23,725	1,019	9
10	26	INSURANCE	AVAIL. BED DAYS	686,836	17	21,145		23,725	730	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	686,836	17	236,117		23,725	8,156	11
12	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	16,611		23,725	574	12
13	32	INTEREST	AVAIL. BED DAYS	686,836	17	1,006		23,725	35	13
14	33	REAL ESTATE TAX	AVAIL. BED DAYS	686,836	17	46,424		23,725	1,604	14
15	34	RENT	AVAIL. BED DAYS	686,836	17	156,000		23,725	5,389	15
16	35	AUTO RENTAL	AVAIL. BED DAYS	686,836	17	18,091		23,725	625	16
17	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	686,836	17	6,400		23,725	221	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,864,985	\$ 1,200,907		\$ 64,423	25

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	1	DIETARY	AVAIL. BED DAYS	686,836	17	\$ 132,684	\$ 123,698	23,725	\$ 4,583	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	686,836	17	15,896		23,725	549	2
3	10	NURSING SALARY	AVAIL. BED DAYS	686,836	17	597,577	597,577	23,725	20,642	3
4	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	686,836	17	38,325		23,725	1,324	4
5	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	686,836	17	74,394		23,725	2,570	5
6	17	ADMINISTRATIVE	AVAIL. BED DAYS	686,836	17	195,987	195,987	23,725	6,770	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	51,975		23,725	1,795	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	849		23,725	29	8
9	21	CLERICAL & GENERAL	AVAIL. BED DAYS	686,836	17	107,160	91,547	23,725	3,702	9
10	24	SEMINARS	AVAIL. BED DAYS	686,836	17	3,858		23,725	133	10
11	25	AUTO AND TRAVEL	AVAIL. BED DAYS	686,836	17	5,508		23,725	190	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	686,836	17	30,309		23,725	1,047	12
13	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	673		23,725	23	13
14	35	AUTO RENTAL	AVAIL. BED DAYS	686,836	17	61,921		23,725	2,139	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,317,116	\$ 1,008,810		\$ 45,496	25

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	\$ 5,168	\$ 20,440	\$ 179	1
	2	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	624	20,440	22	2
	3	21	OFFICE EXPENSE	AVAIL. BED DAYS	686,836	17	1,000	20,440	35	3
	4	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	51,542	20,440	1,780	4
	5	32	INTEREST EXPENSE	AVAIL. BED DAYS	686,836	17	55,103	20,440	1,903	5
	6	33	REAL ESTATE TAXES	AVAIL. BED DAYS	686,836	17	29,058	20,440	1,004	6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$ 142,495	\$		\$ 4,923	25

Facility Name & ID Number Springfield Care Center # 0051086 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 Springfield Care Center # 0051086 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 Springfield Care Center # 0051086 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 Springfield Care Center # 0051086 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 Springfield Care Center # 0051086 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 Springfield Care Center # 0051086 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	Bank Financial		X	Mortgage			\$	1,003,631			\$	56,315	1
2													2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	Bank Financial		X	Line of Credit				152,535				3,520	6
7	Assurance		X	Insurance Financing								948	7
8	See Supplemental Schedule												8
9	TOTAL Facility Related						\$	1,156,166			\$	60,783	9
	B. Non-Facility Related*												
10													10
11	YAM Management Allocation	X										35	11
12	8131 N. Monticello Allocation	X										1,903	12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$				\$	1,938	14
15	TOTALS (line 9+line14)						\$	1,156,166			\$	62,721	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.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term												7
	Working Capital												
8							\$					\$	8
9													9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital												14
	B. Non-Facility Related*												
15							\$					\$	15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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.		\$	16,079	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.)		\$	17,083	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	1,004	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	16,079	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	17,083	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006		8	
		2007		9	
		2008		10	
		2009		11	
		2010	16,079	12	
2011 Accrual = 2010 Tax (Rounded)					
8131 N. Monticello Allocation = \$1,004					

	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>Springfield Care Center</u>	COUNTY	<u>Sangamon</u>
FACILITY IDPH LICENSE NUMBER	<u>0051086</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.

(A)		(B)	(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	14-35.0-157-019	Nursing Home	\$ 16,079.34	\$ 16,079.34
2.	Allocated from 8131 N. Monticello	Home Office Allocation	\$ 35,987.49	\$ 1,088.94
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 52,066.83	\$ 17,168.28

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

C. Tax Bills

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>Springfield Care Center</u>	COUNTY	<u>Sangamon</u>
---------------	--------------------------------	--------	-----------------

FACILITY IDPH LICENSE NUMBER 0051086

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:		B. General Construction Type:	Exterior	Brick	Frame	Wood	Number of Stories	1
------------------------	--	--------------------------------------	----------	-------	-------	------	--------------------------	---

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

[illegible]

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	Centralia Property LLC			\$ 21,056	1
2	Allocated from 8131 N. Monticello			3,074	2
3	TOTALS			\$ 24,130	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	65		2010	1972	\$ 639,905	\$ 9,396	20	\$ 18,283	\$ 8,887	\$ 24,377	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

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)	35,725	1,894		1,261	(633)	1,861	68
69	Financial Statement Depreciation		11,724			(11,724)		69
70	TOTAL (lines 4 thru 69)	\$ 675,630	\$ 23,014		\$ 19,544	\$ (3,470)	\$ 26,238	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Springfield Care Center

0051086

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		\$ 675,630	\$ 23,014		\$ 19,544	\$ (3,470)	\$ 26,238	1
2	Bathrooms, Tile, Walls And Grout	2011	13,000		20	758	758	758	2
3	Water Heater	2011	6,082		20	608	608	608	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
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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)		\$ 694,712	\$ 23,014		\$ 20,910	\$ (2,104)	\$ 27,604	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 694,712	\$ 23,014		\$ 20,910	\$ (2,104)	\$ 27,604	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)		\$ 694,712	\$ 23,014		\$ 20,910	\$ (2,104)	\$ 27,604	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$694,712	\$23,014		\$20,910	\$(2,104)	\$27,604	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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14									14
15									15
16									16
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18									18
19									19
20									20
21									21
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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)		\$694,712	\$23,014		\$20,910	\$(2,104)	\$27,604	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		\$ 694,712	\$ 23,014		\$ 20,910	\$ (2,104)	\$ 27,604	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
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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)		\$ 694,712	\$ 23,014		\$ 20,910	\$ (2,104)	\$ 27,604	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	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
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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	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		\$	\$		\$	\$	\$	1
2 Buildings:								2
3 Allocated from 8131 N. Monticello	2010	23,887	710	39	612	(98)	893	3
4								4
5								5
6								6
7								7
8 Leasehold Improvements:								8
9 Allocated from 8131 N. Monticello	2010	10,700	1,070	20	535	(535)	823	9
10 Allocated from YAM Management	2010	1,138	114	20	114		145	10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34								34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 101,632	\$ 68,433	\$ 14,390	\$ (54,043)	10	\$ 19,037	71
72	Current Year Purchases	92	4	4		10	4	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 101,724	\$ 68,437	\$ 14,394	\$ (54,043)		\$ 19,041	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		YAM MANAGEMENT, LLC	2009	\$ 929	\$ 103	\$ 103		5	\$ 35	76
77										77
78										78
79										79
80	TOTALS			\$ 929	\$ 103	\$ 103			\$ 35	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 821,495	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 91,554	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 35,407	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (56,147)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 46,680	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	48 Windows Heat & Air Units	\$ 21,000	92
93	HVAC 2X5Ton, Air Handlers, & Trane Equip	5,000	93
94			94
95		\$ 26,000	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: \$ 1,913
- 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	Facility	2010 Ford E-350	\$	\$ 4,547	17
18	Allocated from YAM Management			625	18
19	Allocated from YAM Consulting			2,139	19
20					20
21	TOTAL		\$	\$ 7,311	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)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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	N/A	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental									13
14	TOTAL			\$		\$	\$		\$	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 6,866	\$ 7,565	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	419,326	419,326	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	40,968	40,968	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	38,393	191,263	8
9	Other(specify): See Attached Schedule	16,984	16,984	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 522,537	\$ 676,106	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		182,918	13
14	Buildings, at Historical Cost		342,849	14
15	Leasehold Improvements, at Historical Cost	16,537	40,149	15
16	Equipment, at Historical Cost	47,974	230,269	16
17	Accumulated Depreciation (book methods)	(14,588)	(106,935)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	513,782	513,782	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 563,705	\$ 1,203,032	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,086,242	\$ 1,879,138	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 118,287	\$ 118,289	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,181	1,181	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	68,366	68,366	30
31	Accrued Taxes Payable (excluding real estate taxes)	75	75	31
32	Accrued Real Estate Taxes(Sch.IX-B)	16,079	16,079	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	853,805	359,555	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,057,793	\$ 563,545	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	152,535	1,156,166	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule		234,531	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 152,535	\$ 1,390,697	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,210,328	\$ 1,954,242	46
47	TOTAL EQUITY(page 18, line 24)	\$ (124,086)	\$ (75,104)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,086,242	\$ 1,879,138	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (45,665)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (45,665)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(61,754)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(16,667)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (78,421)	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)	\$ (124,086)	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	\$ 1,856,226	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,856,226	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,856,226	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	429,379	31
32	Health Care	779,274	32
33	General Administration	458,482	33
	B. Capital Expense		
34	Ownership	165,668	34
	C. Ancillary Expense		
35	Special Cost Centers	49,589	35
36	Provider Participation Fee	35,588	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,917,980	40
41	Income before Income Taxes (line 30 minus line 40)**	(61,754)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (61,754)	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	1,909	2,043	\$ 58,399	\$ 28.59	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,284	5,562	120,123	21.60	3
4	Licensed Practical Nurses	8,852	9,376	176,744	18.85	4
5	CNAs & Orderlies	23,121	24,677	261,539	10.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	20	22	337	15.32	9
10	Activity Assistants	2,888	3,091	35,671	11.54	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,917	2,043	27,218	13.32	13
14	Head Cook	4,905	5,212	48,511	9.31	14
15	Cook Helpers/Assistants	2,452	2,574	24,198	9.40	15
16	Dishwashers					16
17	Maintenance Workers	2,579	2,750	31,715	11.53	17
18	Housekeepers	7,034	7,520	75,460	10.03	18
19	Laundry	80	86	916	10.65	19
20	Administrator	1,744	1,786	60,751	34.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,964	2,100	23,828	11.35	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	1,971	2,098	57,432	27.38	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	66,721	70,940	\$ 1,002,842 *	\$ 14.14	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	113	\$ 6,246	01-03	35
36	Medical Director	Monthly	10,800	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	263	19,798	10-03	38
39	Pharmacist Consultant	25	1,274	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	643	11-03	44
45	Social Service Consultant	7	337	12-03	45
46	Other(specify)				46
47	Psychiatric M.D.	Monthly	6,543	12-03	47
48					48
49	TOTAL (lines 35 - 48)	420	\$ 45,641		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount		
Jacqueline Liddell (5/1/11- Present)	Administrator	0.00%	\$ 28,360	Workers' Compensation Insurance	\$ 59,963	IDPH License Fee	\$		
Byron Witt (1/1/11-5/1/211)	Administrator	0.00%	32,391	Unemployment Compensation Insurance	31,848	Advertising: Employee Recruitment	480		
				FICA Taxes	74,895	Health Care Worker Background Check			
				Employee Health Insurance	10,433	(Indicate # of checks performed 269)	2,689		
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subcriptions	7,273		
				Dental	109	License & Permits	10,136		
				Life Insurance	67	Advertising & Promotions	995		
				Employee Benefits - Others	600	Allocated from YAM Management	227		
TOTAL (agree to Schedule V, line 17, col. 1)						See Supplemental Schedule	51		
(List each licensed administrator separately.)				\$ 60,751		Less: Public Relations Expense	()		
B. Administrative - Other						Non-allowable advertising	(995)		
Description			Amount			Yellow page advertising	()		
Administrative Consulting - YAM Consulting			\$ 7,000			TOTAL (agree to Sch. V, line 20, col. 8)			
Management Fees - Yosef Meystel			2,000			\$ 20,856			
Management Fees - David Berkowitz			4,000			G. Schedule of Travel and Seminar**			
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 13,000	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Health Data Systems, Inc.	Data Processing		\$ 3,100			\$	Out-of-State Travel	\$	
Legal	See Attached		4,288						
PAS Management, Ltd.	Property Advisory		9,300						
YAM Management	Accounting		12,000				In-State Travel		
YAM Management	Bookkeeping		49,428						
YAM Management	Data Processing		503						
Personnel Planners, Inc.	Unemployment Consultant		2,062				Seminar Expense	1,310	
							Allocated from YAM Management	351	
							Allocated from YAM Consulting	133	
							Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)							TOTAL	\$ 1,794	
(If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 80,681	TOTAL				

*** 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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$7,274
- (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? _____
- (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? 10yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 149 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 35,588
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

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- (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. \$ _____ Has any meal income been offset against related costs? No 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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 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 of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.