

Facility Name & ID Number Concord Extended Care

0026914 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	<u>134</u>	Skilled (SNF)	<u>134</u>	<u>48,910</u>	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	<u>134</u>	TOTALS	<u>134</u>	<u>48,910</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5	
		3 Medicaid Recipient	Private Pay	4 Other	Total		
8	SNF	<u>32,202</u>	<u>5,650</u>	<u>6,411</u>	<u>44,263</u>	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>32,202</u>	<u>5,650</u>	<u>6,411</u>	<u>44,263</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.50%

D. How many bed-hold days during this year were paid by the Department? 9 (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 1962

J. Was the facility purchased or leased after January 1, 1978?
YES Date 1962 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 134 and days of care provided 4,113

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	211,445	33,780	14,286	259,511		259,511	(8,160)	251,351		1
2	Food Purchase		218,321		218,321		218,321	(312)	218,009		2
3	Housekeeping	166,432	29,509		195,941		195,941	(782)	195,159		3
4	Laundry	88,417	12,998		101,415		101,415		101,415		4
5	Heat and Other Utilities			116,281	116,281		116,281	981	117,262		5
6	Maintenance	54,251		107,537	161,788		161,788	19,166	180,954		6
7	Other (specify):*							2,458	2,458		7
8	TOTAL General Services	520,545	294,608	238,104	1,053,257		1,053,257	13,352	1,066,609		8
	B. Health Care and Programs										
9	Medical Director			23,836	23,836		23,836		23,836		9
10	Nursing and Medical Records	2,206,015	191,718	22,381	2,420,114		2,420,114	(678)	2,419,436		10
10a	Therapy	89,708			89,708		89,708	246	89,954		10a
11	Activities	69,449	8,750		78,199		78,199		78,199		11
12	Social Services	17,633		4,886	22,519		22,519	2,518	25,037		12
13	CNA Training										13
14	Program Transportation			1,509	1,509		1,509	1,472	2,981		14
15	Other (specify):*							8,319	8,319		15
16	TOTAL Health Care and Programs	2,382,805	200,468	52,612	2,635,885		2,635,885	11,877	2,647,762		16
	C. General Administration										
17	Administrative	79,222		139,499	218,721		218,721	25,914	244,635		17
18	Directors Fees										18
19	Professional Services			316,675	316,675	(2,750)	313,925	(255,588)	58,337		19
20	Dues, Fees, Subscriptions & Promotions			32,594	32,594		32,594	(4,480)	28,114		20
21	Clerical & General Office Expenses	114,968	6,837	288,873	410,678		410,678	(178,505)	232,173		21
22	Employee Benefits & Payroll Taxes			468,170	468,170		468,170	(740)	467,430		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,645	2,645		2,645	1,061	3,706		24
25	Other Admin. Staff Transportation			1,488	1,488		1,488	937	2,425		25
26	Insurance-Prop.Liab.Malpractice			140,521	140,521		140,521	836	141,357		26
27	Other (specify):*							19,200	19,200		27
28	TOTAL General Administration	194,190	6,837	1,390,465	1,591,492	(2,750)	1,588,742	(391,365)	1,197,377		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,097,540	501,913	1,681,181	5,280,634	(2,750)	5,277,884	(366,135)	4,911,749		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.

Facility Name & ID Number

Concord Extended Care

#0026914

Report Period Beginning:

01/01/09

Ending:

12/31/09

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			34,983	34,983		34,983	114,266	149,249			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,774	42,774		42,774	(17,900)	24,874			32
33	Real Estate Taxes			242,051	242,051	2,750	244,801	188,940	433,741			33
34	Rent-Facility & Grounds			613,966	613,966		613,966	(82,350)	531,616			34
35	Rent-Equipment & Vehicles			9,425	9,425		9,425	5,889	15,314			35
36	Other (specify):*			205,938	205,938		205,938	(202,786)	3,152			36
37	TOTAL Ownership			1,149,137	1,149,137	2,750	1,151,887	6,058	1,157,945			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		171,471	297,676	469,147		469,147	(5,490)	463,657			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			73,365	73,365		73,365		73,365			42
43	Other (specify):*	28,874			28,874		28,874	(28,874)	(0)			43
44	TOTAL Special Cost Centers	28,874	171,471	371,041	571,386		571,386	(34,364)	537,022			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,126,414	673,384	3,201,359	7,001,157		7,001,157	(394,442)	6,606,715			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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/09

Ending:

12/31/09

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	97,212	30		9
10	Interest and Other Investment Income	(69,951)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(279)	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	(1,157)	21		18
19	Entertainment	(2,638)	21		19
20	Contributions	(630)	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	(40,006)	21		24
25	Fund Raising, Advertising and Promotional	(5,159)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,400)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(243)	20		28
29	Other-Attach Schedule	(771,829)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (797,080)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	402,638		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 402,638		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (394,442)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		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

SEE ACCOUNTANTS' COMPILATION REPORT

BHF USE ONLY							
48		49		50		51	52

Concord Extended Care

ID# 0026914

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Other Income	\$ (5,049)	21	1
2	Loss on Disposal of Asset	(205,938)	36	2
3	Patient Clothing	(60)	10	3
4	Veterans Expense	(2,889)	10	4
5	Building Co. - Fees	(3,554)	19	5
6	Building Co. - Amortization	(374)	36	6
7	Building Co. - License & Fees	(42)	20	7
8	Non - Allowable Legal	(75,671)	19	8
9	Veterans Expense	(22,118)	10	9
10	Marketing	(28,874)	43	10
11	Bank Charges	(464)	21	11
12	Cable T.V.	(3,184)	06	12
13	Marketing Fees	(19,725)	21	13
14	Annual Report Fee	(504)	20	14
15	Non-Allowable Office Expense	(135,748)	21	15
16	Non-Allowable Professional	(3,650)	19	16
17	Non - Allowable Real Estate Tax Expense	(242,051)	33	17
18	Non - Allowable Expense	(29,400)	21	18
19	Additional R&M	7,466	06	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	(771,829)		49

Concord Extended Care

ID# 0026914

Report Period Beginning: 01/01/09

Ending: 12/31/09

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Concord Extended Care# 0026914

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				(6,306)	36		629				(2,519)	(8,160)	1
2	Food Purchase	(279)				81						(114)	(312)	2
3	Housekeeping					75		8	(865)				(782)	3
4	Laundry													4
5	Heat and Other Utilities			551		309		20				101	981	5
6	Maintenance	4,282	1,851	3,734	7,284	479	1,174	3			282	77	19,166	6
7	Other (specify):*			952	1,207		208	91					2,458	7
8	TOTAL General Services	4,004	1,851	5,237	2,185	980	1,382	751	(865)		282	(2,455)	13,352	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(25,067)			21,902			4,284	(1,797)				(678)	10
10a	Therapy							246					246	10a
11	Activities													11
12	Social Services				1,193			1,325					2,518	12
13	CNA Training													13
14	Program Transportation				1,472								1,472	14
15	Other (specify):*				7,248			1,071					8,319	15
16	TOTAL Health Care and Programs	(25,067)			31,815			6,926	(1,797)				11,877	16
	C. General Administration													
17	Administrative			10,191	5,600	353	1,282	5,588				2,900	25,914	17
18	Directors Fees													18
19	Professional Services	(82,875)	3,554	(95,688)	(9,446)	(52,934)		(18,322)			15	108	(255,588)	19
20	Fees, Subscriptions & Promotions	(6,578)	42	199	1,509	303		1				44	(4,480)	20
21	Clerical & General Office Expenses	(236,587)		44,034	(10,513)	2,476	19,277	1,253			(1,954)	3,509	(178,505)	21
22	Employee Benefits & Payroll Taxes						(556)	(155)	(29)				(740)	22
23	Inservice Training & Education													23
24	Travel and Seminar			388	519	9		145					1,061	24
25	Other Admin. Staff Transportation			670	128	55					1	83	937	25
26	Insurance-Prop.Liab.Malpractice			486		121		7			16	206	836	26
27	Other (specify):*			11,347	2,070		3,546	971				1,266	19,200	27
28	TOTAL General Administration	(326,040)	3,596	(28,373)	(10,133)	(49,617)	23,549	(10,512)	(29)		(1,922)	8,116	(391,365)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(347,103)	5,447	(23,136)	23,867	(48,637)	24,931	(2,835)	(2,691)		(1,640)	5,661	(366,135)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Concord Extended Care# 0026914

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	97,212	12,804	894	43	619		137			2,345	212	114,266	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(69,951)	40,842	41		9,097		1,656			415		(17,900)	32
33	Real Estate Taxes	(242,051)	430,661			298		32					188,940	33
34	Rent-Facility & Grounds		(88,000)	4,185		518						947	(82,350)	34
35	Rent-Equipment & Vehicles			870	4,642	366						10	5,889	35
36	Other (specify):*	(206,312)	3,526										(202,786)	36
37	TOTAL Ownership	(421,102)	399,833	5,990	4,685	10,898		1,825			2,760	1,169	6,058	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(1,671)		(2,870)	(949)	(5,490)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(28,874)											(28,874)	43
44	TOTAL Special Cost Centers	(28,874)							(1,671)		(2,870)	(949)	(34,364)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(797,080)	405,280	(17,145)	28,552	(37,739)	24,931	(1,010)	(4,362)		(1,750)	5,881	(394,442)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Concord Health Care Properties LLC		Building Co.

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	\$ 88,000	Concord Health Care Properties, LLC		\$	(88,000)	1	
2	V	32 Interest	8	Concord Health Care Properties, LLC		40,850	40,842	2	
3	V	19 Legal Fee		Concord Health Care Properties, LLC		1,887	1,887	3	
4	V	19 Audit Fee		Concord Health Care Properties, LLC		1,667	1,667	4	
5	V	21 Bank Fees		Concord Health Care Properties, LLC				5	
6	V	06 Repairs & Maintenance		Concord Health Care Properties, LLC		1,851	1,851	6	
7	V	36 Amortization		Concord Health Care Properties, LLC		374	374	7	
8	V	33 Real Estate Taxes		Concord Health Care Properties, LLC		430,661	430,661	8	
9	V	26 Insurance		Concord Health Care Properties, LLC				9	
10	V	20 Licenses & Fees		Concord Health Care Properties, LLC		42	42	10	
11	V	36 MIP Expense		Concord Health Care Properties, LLC		3,152	3,152	11	
12	V	30 Depreciation		Concord Health Care Properties, LLC		12,804	12,804	12	
13	V							13	
14	Total		\$ 88,008			\$ 493,288	\$ *	405,280	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	YAM MANAGEMENT, LLC	100.00%	\$ 551	\$	551	15
16	V	6 REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	3,734		3,734	16
17	V	7 EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	952		952	17
18	V	17 ADMIN. - RELATED		YAM MANAGEMENT, LLC	100.00%	4,753		4,753	18
19	V	17 ADMIN. - NON RELATED		YAM MANAGEMENT, LLC	100.00%	5,438		5,438	19
20	V	19 PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	3,102		3,102	20
21	V	20 FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	199		199	21
22	V	21 CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	44,034		44,034	22
23	V	24 SEMINARS		YAM MANAGEMENT, LLC	100.00%	388		388	23
24	V	25 AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	670		670	24
25	V	26 INSURANCE		YAM MANAGEMENT, LLC	100.00%	486		486	25
26	V	27 EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	11,347		11,347	26
27	V	30 DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	894		894	27
28	V	32 INTEREST		YAM MANAGEMENT, LLC	100.00%	41		41	28
29	V	34 RENT		YAM MANAGEMENT, LLC	100.00%	4,185		4,185	29
30	V	35 AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	675		675	30
31	V	35 EQUIPMENT RENTAL		YAM MANAGEMENT, LLC	100.00%	195		195	31
32	V								32
33	V	19 BOOKKEEPING FEES	70,790	YAM MANAGEMENT, LLC	100.00%			(70,790)	33
34	V	19 ACCOUNTING	28,000	YAM MANAGEMENT, LLC	100.00%			(28,000)	34
35	V	17 MANAGEMENT FEES		YAM MANAGEMENT, LLC	100.00%				35
36	V								36
37	V								37
38	V								38
39	Total		\$ 98,790			\$ 81,645	\$ *	(17,145)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 DIETARY	\$	YAM CONSULTING, LLC	100.00%	\$ 7,284	\$	7,284	15
16	V	7 EMP. BEN. GEN. SERV.		YAM CONSULTING, LLC	100.00%	1,207		1,207	16
17	V	10 NURSING SALARY		YAM CONSULTING, LLC	100.00%	39,399		39,399	17
18	V	12 SOCIAL SERVICES SALARY		YAM CONSULTING, LLC	100.00%	4,713		4,713	18
19	V	14 PROGRAM TRANSPORTATION		YAM CONSULTING, LLC	100.00%	1,472		1,472	19
20	V	15 EMP. BEN. HEALTHCARE		YAM CONSULTING, LLC	100.00%	7,248		7,248	20
21	V	17 ADMIN. - NON RELEATED		YAM CONSULTING, LLC	100.00%	5,600		5,600	21
22	V	19 PROFESSIONAL FEES		YAM CONSULTING, LLC	100.00%	534		534	22
23	V	20 FEES, SUBSCRIPTIONS		YAM CONSULTING, LLC	100.00%	1,509		1,509	23
24	V	21 CLERICAL & GENERAL		YAM CONSULTING, LLC	100.00%	7,787		7,787	24
25	V	24 SEMINARS		YAM CONSULTING, LLC	100.00%	519		519	25
26	V	25 AUTO AND TRAVEL		YAM CONSULTING, LLC	100.00%	128		128	26
27	V	27 EMP. BEN.-GEN. ADMIN.		YAM CONSULTING, LLC	100.00%	2,070		2,070	27
28	V	30 DEPRECIATION		YAM CONSULTING, LLC	100.00%	43		43	28
29	V	35 AUTO RENTAL		YAM CONSULTING, LLC	100.00%	4,642		4,642	29
30	V								30
31	V								31
32	V								32
33	V	12 SOCIAL WORK CONSULTING	3,520					(3,520)	33
34	V	10 NURSING CONSULTING	17,497					(17,497)	34
35	V	01 DIETICIAN CONSULTING	6,306					(6,306)	35
36	V	19 DATA PROCESSING FEES	9,980					(9,980)	36
37	V	21 MARKETING	18,300					(18,300)	37
38	V								38
39	Total		\$ 55,603			\$ 84,155	\$ *	28,552	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	01 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 36	\$	36	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	81		81	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	75		75	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	309		309	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	479		479	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	353		353	20
21	V	19 Professional Fees	54,463	Extended Care Consulting, LLC	100.00%	1,529		(52,934)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	303		303	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	2,476		2,476	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	9		9	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	55		55	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	121		121	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	619		619	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	9,097		9,097	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	298		298	29
30	V	34 Rent - Building		Extended Care Consulting, LLC	100.00%	518		518	30
31	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	366		366	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 54,463			\$ 16,724	\$ *	(37,739)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	06 Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	1,174	\$	1,174	15
16	V	06 Maintenance (Direct)	71	Extended Care Consulting, LLC	100.00%	71			16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	201		201	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	7		7	18
19	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	1,282		1,282	19
20	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	19,277		19,277	20
21	V	21 Office and Clerical (Direct)	2,573	Extended Care Consulting, LLC	100.00%	2,573			21
22	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	3,298		3,298	22
23	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	248		248	23
24	V	22 Employee Benefits	556	Extended Care Consulting, LLC	100.00%			(556)	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		\$ 3,200			\$ 28,131	\$ *	24,931	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	03 Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 8	\$ 8
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	20	20
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	3	3
18	V	19 Professional Fees	18,494	Extended Care Clinical, LLC	100.00%	172	(18,322)
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	1	1
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	146	146
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	145	145
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	7	7
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	137	137
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	1,656	1,656
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	32	32
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	629	629
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	91	91
28	V	10 Nursing Salary	473	Extended Care Clinical, LLC	100.00%	4,757	4,284
29	V	10a Rehab Salary		Extended Care Clinical, LLC	100.00%	246	246
30	V	12 Social Service Salary	300	Extended Care Clinical, LLC	100.00%	1,625	1,325
31	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	1,071	1,071
32	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	5,588	5,588
33	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	1,107	1,107
34	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	971	971
35	V	22 Employee Benefits	155	Extended Care Clinical, LLC	100.00%		(155)
36	V						
37	V						
38	V						
39	Total		\$ 19,422			\$ 18,412	\$ * (1,010)

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	9,418	Xcel Supply, LLC	100.00%	8,553	(865)	16
17	V	4 Laundry		Xcel Supply, LLC	100.00%			17
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	19,569	Xcel Supply, LLC	100.00%	17,772	(1,797)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits	320	Xcel Supply, LLC	100.00%	291	(29)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	18,195	Xcel Supply, LLC	100.00%	16,524	(1,671)	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		\$ 47,502			\$ 43,140	\$ * (4,362)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 35,320	\$ 35,320	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	35,320	CCS Employee Benefits Group	100.00%		(35,320)	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		\$ 35,320			\$ 35,320	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	06 Repairs	\$	Vent Lease, LLC.	100.00%	\$ 282	\$	282	15
16	V	19 Professional Fees		Vent Lease, LLC.	100.00%	15		15	16
17	V	21 Office and Clerical		Vent Lease, LLC.	100.00%	24		24	17
18	V	25 Auto Expense / Travel		Vent Lease, LLC.	100.00%	1		1	18
19	V	26 Insurance		Vent Lease, LLC.	100.00%	16		16	19
20	V	30 Depreciation		Vent Lease, LLC.	100.00%	735		735	20
21	V	32 Interest		Vent Lease, LLC.	100.00%	124		124	21
22	V	30 Depreciation - Matrix		Vent Lease, LLC.	100.00%	1,610		1,610	22
23	V	32 Interest - Matrix		Vent Lease, LLC.	100.00%	291		291	23
24	V	21 Office and Clerical	1,978	Vent Lease, LLC.	100.00%			(1,978)	24
25	V	39 Ancillary	2,870	Vent Lease, LLC.	100.00%			(2,870)	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		\$ 4,848			\$ 3,098	\$ *	(1,750)	39

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

Facility Name & ID Number

Concord Extended Care

0026914

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	01 Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$ 1,335	\$ 1,335	15
16	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%			16
17	V	05 Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	101	101	17
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%	77	77	18
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%	108	108	19
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	44	44	20
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	549	549	21
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	83	83	22
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%	206	206	23
24	V	30 Depreciation		Care Centers Health Systems, Inc.	100.00%	212	212	24
25	V	32 Interest		Care Centers Health Systems, Inc.	100.00%			25
26	V	33 Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%			26
27	V	34 Rent - Building		Care Centers Health Systems, Inc.	100.00%	947	947	27
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	10	10	28
29	V	01 Dietary	6,414	Care Centers Health Systems, Inc.	100.00%	2,560	(3,854)	29
30	V	02 Food	190	Care Centers Health Systems, Inc.	100.00%	76	(114)	30
31	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%			31
32	V	10 Nursing		Care Centers Health Systems, Inc.	100.00%			32
33	V	22 Employee Benefits		Care Centers Health Systems, Inc.	100.00%			33
34	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%			34
35	V	39 Ancillary	1,580	Care Centers Health Systems, Inc.	100.00%	631	(949)	35
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	2,900	2,900	36
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	2,960	2,960	37
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	1,266	1,266	38
39	Total		\$ 8,184			\$ 14,065	\$ * 5,881	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Concord Extended Care

0026914

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	Owner	Administration	11.00%	See Attached	3.20	8.00%	Mgmt. Fees	\$ 14,000	17-03	1
2	Steven Blisko	Owner	Administration	30.00%	See Attached	20.00	50.00%	Mgmt. Fees	86,124	17-03	2
3	Joseph Blisko	Owner	Administration	15.00%	None	0.00	0.00%	Mgmt. Fees	14,375	17-03	3
4	Jay Meystel	Owner	Administration	12.50%	See Attached	1.60	4.00%	Alloc. Salary	2,922	17-07	4
5	Joel Meystel	Relative	Administration	0.00%	See Attached	1.60	8.00%	Alloc. Salary	1,832	17-07	5
6	David Berkowitz	Owner	Administration	23.50%	See Attached	0.00	0.00%	Mgmt. Fees	25,000	17-03	6
7											7
8	Eric Rothner	Owner	Administration	33.00%	See Attached	0.16	0.34%				8
9	Mark Steinberg	Relative	Administration	0.00%	See Attached	0.29	0.53%	Alloc. Salary	892	17-7	9
10	Noah Wolff	Owner	Administration	16.67%	See Attached	2.00	9.09%				10
11	Adam Vales	Relative	Clerical	0.00%	See Attached	0.21	0.53%	Alloc. Salary	371	22-7	11
12											12
13								TOTAL	\$ 145,516		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 Concord Extended Care

0026914

Report Period Beginning:

01/01/09

Ending: 12/31/09

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 3501 W. HOWARD STREET
 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 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	5	UTILITIES	AVAIL. BED DAYS	516,637	12	\$ 6,943	\$ 41,004	\$ 551	1	
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	516,637	12	47,049	41,077	41,004	3,734	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	516,637	12	11,995	41,004	952	3	
4	17	ADMIN. - RELATED	AVAIL. BED DAYS	516,637	12	59,890	59,890	41,004	4,753	4
5	17	ADMIN. - NON RELATED	AVAIL. BED DAYS	516,637	12	68,520	68,520	41,004	5,438	5
6	19	PROFESSIONAL FEES	AVAIL. BED DAYS	516,637	12	39,084	41,004	3,102	6	
7	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	516,637	12	2,504	41,004	199	7	
8	21	CLERICAL & GENERAL	AVAIL. BED DAYS	516,637	12	554,814	499,630	41,004	44,034	8
9	24	SEMINARS	AVAIL. BED DAYS	516,637	12	4,893	41,004	388	9	
10	25	AUTO AND TRAVEL	AVAIL. BED DAYS	516,637	12	8,444	41,004	670	10	
11	26	INSURANCE	AVAIL. BED DAYS	516,637	12	6,121	41,004	486	11	
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	516,637	12	142,965	41,004	11,347	12	
13	30	DEPRECIATION	AVAIL. BED DAYS	516,637	12	11,270	41,004	894	13	
14	32	INTEREST	AVAIL. BED DAYS	516,637	12	513	41,004	41	14	
15	34	RENT	AVAIL. BED DAYS	516,637	12	52,725	41,004	4,185	15	
16	35	AUTO RENTAL	AVAIL. BED DAYS	516,637	12	8,509	41,004	675	16	
17	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	516,637	12	2,458	41,004	195	17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,028,697	\$ 669,116	\$ 81,645	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/09

Ending: 12/31/09

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

3501 W. HOWARD STREET

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 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	6	DIETARY	AVAIL. BED DAYS	516,637	12	\$ 91,773	\$ 89,792	41,004	\$ 7,284	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	516,637	12	15,208		41,004	1,207	2
3	10	NURSING SALARY	AVAIL. BED DAYS	516,637	12	496,414	496,414	41,004	39,399	3
4	12	SOCIAL SERVICES SALARY	AVAIL. BED DAYS	516,637	12	59,382	59,382	41,004	4,713	4
5	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	516,637	12	18,550		41,004	1,472	5
6	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	516,637	12	91,325		41,004	7,248	6
7	17	ADMIN. - NON RELEATED	AVAIL. BED DAYS	516,637	12	70,560	70,560	41,004	5,600	7
8	19	PROFESSIONAL FEES	AVAIL. BED DAYS	516,637	12	6,724		41,004	534	8
9	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	516,637	12	19,007		41,004	1,509	9
10	21	CLERICAL & GENERAL	AVAIL. BED DAYS	516,637	12	98,110	79,705	41,004	7,787	10
11	24	SEMINARS	AVAIL. BED DAYS	516,637	12	6,543		41,004	519	11
12	25	AUTO AND TRAVEL	AVAIL. BED DAYS	516,637	12	1,616		41,004	128	12
13	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	516,637	12	26,075		41,004	2,070	13
14	30	DEPRECIATION	AVAIL. BED DAYS	516,637	12	539		41,004	43	14
15	35	AUTO RENTAL	AVAIL. BED DAYS	516,637	12	58,491		41,004	4,642	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,060,316	\$ 795,852		\$ 84,155	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 Extended Care Consulting LLC
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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	01	Dietary	Patient Days	30	\$ 6,770	\$	7,370	\$ 36	1
2	02	Food	Patient Days	30	15,058		7,370	81	2
3	03	Housekeeping	Patient Days	30	14,059		7,370	75	3
4	05	Utilities	Patient Days	30	57,646		7,370	309	4
5	06	Maintenance	Patient Days	30	89,465		7,370	479	5
6	17	Administrative	Patient Days	30	66,000		7,370	353	6
7	19	Professional Fees	Patient Days	30	285,482		7,370	1,529	7
8	20	Dues and Subscriptions	Patient Days	30	56,488		7,370	303	8
9	21	Office and Clerical	Patient Days	30	462,313		7,370	2,476	9
10	24	Seminar and Travel	Patient Days	30	1,768		7,370	9	10
11	25	Other Staff Admin. Trans.	Patient Days	30	10,309		7,370	55	11
12	26	Insurance	Patient Days	30	22,668		7,370	121	12
13	30	Depreciation	Patient Days	30	115,549		7,370	619	13
14	32	Interest	Patient Days	30	1,698,489		7,370	9,097	14
15	33	Real Estate Taxes	Patient Days	30	55,709		7,370	298	15
16	34	Rent - Building	Patient Days	30	96,636		7,370	518	16
17	35	Rent - Equipment & Auto	Patient Days	30	68,244		7,370	366	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,122,653	\$		\$ 16,724	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 Extended Care Consulting LLC
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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	06	Maintenance (Pooled)	Patient Days	1,376,056	30	219,177	219,177	7,370	1,174	1
2	06	Maintenance (Direct)	Direct		30	82,905	82,905		71	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,376,056	30	37,501		7,370	201	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		30	8,464	8,464		7	4
5	17	Administrative (Pooled)	Patient Days	1,376,056	30	239,303	239,303	7,370	1,282	5
6	21	Office and Clerical (Pooled)	Patient Days	1,376,056	30	3,599,211	3,599,211	7,370	19,277	6
7	21	Office and Clerical (Direct)	Direct		30	654,174			2,573	7
8	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,376,056	30	615,819	615,819	7,370	3,298	8
9	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		30	73,650	73,650	7,370	248	9
10	22	Employee Benefits								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					\$ 5,530,203	\$ 4,838,529		\$ 28,131	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 Extended Care Clinical LLC
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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	03	Housekeeping	Patient Days	1,376,056	30	\$ 1,549	\$ 7,370	\$ 8	1
2	05	Utilities	Patient Days	1,376,056	30	3,693	7,370	20	2
3	06	Maintenance	Patient Days	1,376,056	30	477	7,370	3	3
4	19	Professional Fees	Patient Days	1,376,056	30	32,105	7,370	172	4
5	20	Dues and Subscriptions	Patient Days	1,376,056	30	213	7,370	1	5
6	21	Office & Clerical	Patient Days	1,376,056	30	27,296	7,370	146	6
7	24	Travel and Seminar	Patient Days	1,376,056	30	27,079	7,370	145	7
8	26	Insurance	Patient Days	1,376,056	30	1,342	7,370	7	8
9	30	Depreciation	Patient Days	1,376,056	30	25,586	7,370	137	9
10	32	Interest	Patient Days	1,376,056	30	309,136	7,370	1,656	10
11	33	Real Estate Taxes	Patient Days	1,376,056	30	6,053	7,370	32	11
12	01	Dietary Salary	Patient Days	1,376,056	30	117,506	7,370	629	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,376,056	30	17,040	7,370	91	13
14	10	Nursing Salary	Patient Days	1,376,056	30	799,889	7,370	4,284	14
15	10a	Rehab Salary	Patient Days	1,376,056	30	45,993	7,370	246	15
16	12	Social Service Salary	Patient Days	1,376,056	30	247,396	7,370	1,325	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,376,056	30	158,537	7,370	849	17
18	17	Administration Salary	Patient Days	1,376,056	30	1,043,375	7,370	5,588	18
19	21	Office Salary	Patient Days	1,376,056	30	206,680	7,370	1,107	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,376,056	30	181,271	7,370	971	20
21	10	Nursing Salary	Direct Allocation			494,488	7,370	473	21
22	12	Social Service Salary	Direct Allocation			196,033		300	22
23	15	Emp. Ben. - Healthcare	Direct Allocation			82,560		222	23
24									24
25	TOTALS					\$ 4,025,296	\$ 3,151,360	\$ 18,412	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 Xcel Supply, LLC
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, IL 60202
 Phone Number (847)328-7600
 Fax Number (847)328-7615

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	Dietary	Direct Allocation		\$	\$		\$	1
2	3	Housekeeping	Direct Allocation					8,553	2
3	4	Laundry	Direct Allocation						3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					17,772	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation					291	10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					16,524	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				\$	\$		\$	43,140

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 CCS Employee Benefits Group, Inc.
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847)905-4000
 Fax Number (847)905-4040

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	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 35,320	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				\$	\$		\$ 35,320	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 Vent Lease, LLC
 Street Address 2201 W. Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 674-1180
 Fax Number (847) 673-7741

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	06	Repairs	Direct Billing	821,185	26	\$ 80,807	\$ 2,870	\$ 282	1
2	19	Professional Fees	Direct Billing	821,185	26	4,427	2,870	15	2
3	21	Office and Clerical	Direct Billing	821,185	26	6,852	2,870	24	3
4	25	Auto Expense / Travel	Direct Billing	821,185	26	356	2,870	1	4
5	26	Insurance	Direct Billing	821,185	26	4,573	2,870	16	5
6	30	Depreciation	Direct Billing	821,185	26	218,810	2,870	735	6
7	32	Interest	Direct Billing	821,185	26	35,420	2,870	124	7
8	30	Depreciation - Matrix	Patient Days	1,376,056	30	300,546	7,370	1,610	8
9	32	Interest - Matrix	Patient Days	1,376,056	30	54,323	7,370	291	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					\$ 706,114	\$	\$ 3,098	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care# 0026914

Report Period Beginning:

01/01/09Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Care Centers Health Systems, Inc.

Street Address

200 Howard

City / State / Zip Code

Des Plaines, Illinois 60018

Phone Number

(224) 612-5662

Fax Number

(224) 612-5862

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.

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	01	Dietary	Gross Billable Income	3,421,940	26	72,652	62,889	1,335	1
2	03	Housekeeping	Gross Billable Income	3,421,940	26		62,889		2
3	05	Heat and Other Utilities	Gross Billable Income	3,421,940	26	5,507	62,889	101	3
4	06	Maintenance	Gross Billable Income	3,421,940	26	4,211	62,889	77	4
5	19	Professional Fees	Gross Billable Income	3,421,940	26	5,880	62,889	108	5
6	20	Dues, Fees, Subscriptions	Gross Billable Income	3,421,940	26	2,401	62,889	44	6
7	21	Clerical and General Office	Gross Billable Income	3,421,940	26	29,869	62,889	549	7
8	25	Other Admin. Staff Transport.	Gross Billable Income	3,421,940	26	4,509	62,889	83	8
9	26	Insurance	Gross Billable Income	3,421,940	26	11,210	62,889	206	9
10	30	Depreciation	Gross Billable Income	3,421,940	26	11,528	62,889	212	10
11	32	Interest	Gross Billable Income	3,421,940	26		62,889		11
12	33	Real Estate Taxes	Gross Billable Income	3,421,940	26		62,889		12
13	34	Rent - Building	Gross Billable Income	3,421,940	26	51,522	62,889	947	13
14	35	Rent - Equipment	Gross Billable Income	3,421,940	26	547	62,889	10	14
15	01	Dietary	Direct Billable Income	206,522	26	82,445	6,414	2,560	15
16	02	Food	Direct Billable Income	2,784	26	1,111	190	76	16
17	03	Housekeeping	Direct Billable Income		26				17
18	10	Nursing	Direct Billable Income	5,466	26	2,182			18
19	22	Employee Benefits	Direct Billable Income	411	26	164			19
20	25	Other Admin. Staff Transport.	Direct Billable Income		26				20
21	39	Ancillary	Direct Billable Income	3,206,757	26	1,280,152	1,580	631	21
22	17	Administrative	Gross Billable Income	3,421,940	26	157,769	157,769	2,900	22
23	21	Clerical and General Office	Gross Billable Income	3,421,940	26	161,081	161,081	2,960	23
24	27	Employee Benefits	Gross Billable Income	3,421,940	26	68,860	62,889	1,266	24
25	TOTALS					\$ 1,953,599	\$ 318,850	\$ 14,065	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Concord Extended Care

0026914

Report Period Beginning:

01/01/09

Ending:

12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	HUD Mortgage		X	Mortgage Loan			\$	\$ 3,749,518		\$ 40,850	1								
2											2								
3											3								
4											4								
5	See Supplemental Schedule										5								
Working Capital																			
6	Diawa Loan		X	Working Capital						20,742	6								
7	Private Bank		X	Line of Credit				400,000	04/13/2010	6.0000	18,077	7							
8	See Supplemental Schedule									15,164	8								
9	TOTAL Facility Related						\$	\$ 4,149,518		\$ 94,832	9								
B. Non-Facility Related*																			
10	Interest Income									(69,951)	10								
11	Interest Income - Bldg. Co.									(8)	11								
12	Allocated from ECC										12								
13	See Supplemental Schedule										13								
14	TOTAL Non-Facility Related						\$	\$		\$ (69,959)	14								
15	TOTALS (line 9+line14)						\$	\$ 4,149,518		\$ 24,873	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 3,152 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Concord Extended Care

0026914

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	Alloc. from YAM Mgmt		X							\$ 41	8									
9	Financing Interest		X							3,955	9									
10	Alloc from Ext Care Conslt, Inc		X							9,097	10									
11	Alloc from Ext Care Clinical		X							1,656	11									
12	Alloc from Vent Lease		X							415	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.)

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,133 B. General Construction Type: Exterior Brick Frame 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.

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

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

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:

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and an index column. Rows include Facility, Alloc. from Ext. Care Conslt/ Ext Care Clinical 2201 Main, and TOTALS.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		1974	1,435		20			1,435	9
10	Various		1976	4,663		20			4,663	10
11	Various		1977	2,336		20			2,336	11
12	Various		1978	765		20			765	12
13	Various		1980	33,145		20			33,145	13
14	Various		1982	2,378		20			2,292	14
15	Various		1983	45,375		20			45,265	15
16	Various		1985	21,344		20			34,699	16
17	Various		1986	31,133		20			31,065	17
18	Various		1988	41,219		20	694	694	34,627	18
19	Various		1989	3,324		20	69	69	3,278	19
20	Various		1990	8,400		20	420	420	8,015	20
21	Various		1991	34,006		20	1,702	1,702	31,963	21
22	Various		1992	8,695		20	435	435	7,547	22
23	Various		1993	11,679		20	585	585	9,751	23
24	Various		1994	29,410		20	1,472	1,472	22,879	24
25	Various		1995	118,494		20	5,927	5,927	84,802	25
26	Various		1996	68,945		20	3,449	3,449	45,621	26
27	Various		1997	54,013		20	2,701	2,701	33,624	27
28	Various		1998	158,651		20	7,933	7,933	91,104	28
29	Various		1999	40,891		20	2,045	2,045	22,229	29
30	Various		2000	123,534		20	6,179	6,179	58,012	30
31	Various		2001	17,052		20	777	777	6,111	31
32	Various		2002	17,598		20	1,384	1,384	14,937	32
33	Various		2003	24,512		20	2,185	2,185	14,204	33
34	Various		2004	81,602		20	7,880	7,880	46,557	34
35	Various		2005	1,823		20	(133)	(133)	(825)	35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	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)	2,115,488	12,804		59,194	46,390	1,074,040	67
68	Related Party Allocations (Pages 12H & 12I)	10,109	555		684	129	3,541	68
69	Financial Statement Depreciation		34,983			(34,983)		69
70	TOTAL (lines 4 thru 69)	\$ 3,112,019	\$ 48,342		\$ 105,582	\$ 57,240	\$ 1,767,682	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,112,019	\$ 48,342		\$ 105,582	\$ 57,240	\$ 1,767,682	1
2	Guardian Air Units	2006	6,750		20	675	675	2,700	2
3	Line Location Proposal	2006	675		20	68	68	259	3
4	Lovitt & Sons	2006	3,133		20	209	209	653	4
5	35' Interior Drain Tile Installation	2007	7,248		20	725	725	2,054	5
6	Painting (Transfer Expense From Home Office)	2007	56,787		20			56,787	6
7	Corridors	2007	2,506		20	251	251	522	7
8	Baseboard Covers	2007	5,445		20	545	545	1,134	8
9	5 Ton Ac Unit	2007	9,500		20	950	950	1,979	9
10	Painting (Transfer Expense From Home Office)	2007	14,359		20			14,359	10
11	Paint	2008	3,003		20	250	250	3,003	11
12	Painting (Transfer Expense From Home Office)	2008	16,247		20	1,354	1,354	16,247	12
13	Painting (Transfer Expense From Home Office)	2008	15,894		20	2,649	2,649	15,894	13
14	Telephone Cabling	2008	3,380		20	338	338	620	14
15	Bedroom Signs	2008	2,688		20	269	269	493	15
16	Telephone Cabling	2008	4,380		20	438	438	803	16
17	Laundry Room - Power Lines, Vent, Drywall, Paint, Tile	2008	5,900		20	590	590	934	17
18	Elevator - Full Load Pressure Test, Guard Rail, Rewire	2008	5,200		20	260	260	390	18
19	Seal & Coat Parking Lot	2008	2,600		20	260	260	412	19
20	Phone Wiring	2008	2,500		20	250	250	333	20
21	Cable/Cameras/Labor	2009	11,266		20	329	329	329	21
22	Wire Building	2009	9,950		20	332	332	332	22
23	Flooring	2009	59,050		20	1,968	1,968	1,968	23
24	Nurse Station	2009	18,000		20	525	525	525	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)		\$ 3,378,480	\$ 48,342		\$ 118,817	\$ 70,475	\$ 1,890,412	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 Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,378,480	\$ 48,342		\$ 118,817	\$ 70,475	\$ 1,890,412	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)	\$ 3,378,480	\$ 48,342		\$ 118,817	\$ 70,475	\$ 1,890,412	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 Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$ 3,378,480	\$ 48,342		\$ 118,817	\$ 70,475	\$ 1,890,412
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 3,378,480	\$ 48,342		\$ 118,817	\$ 70,475	\$ 1,890,412

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,378,480	\$ 48,342		\$ 118,817	\$ 70,475	\$ 1,890,412	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)	\$ 3,378,480	\$ 48,342		\$ 118,817	\$ 70,475	\$ 1,890,412	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1								1
2								2
3	1962	371,832		39				3
4	1988	1,529,289		39	48,540	48,540	1,021,551	4
5	1962	112,250		39				5
6								6
7								7
8								8
9	2004	63,738		20	7,675	7,675	42,077	9
10	2005	6,103		20	611	611	2,837	10
11	2006	3,133		20	157	157	523	11
12	2006	5,000		10	500	500	1,583	12
13	2006	9,169		10	917	917	3,591	13
14	2007	4,875		20	290	290	870	14
15	2008	3,085		20	154	154	308	15
16	2008	3,868		20	193	193	386	16
17	2008	3,146		20	157	157	314	17
18								18
19								19
20								20
21			12,804			(12,804)		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.

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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	TOTAL (12F & 12G lines 1 thru 33)	\$ 2,115,488	\$ 12,804		\$ 59,194	\$ 46,390	\$ 1,074,040	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	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 Extended Care Consulting, 2201 Main LLC	2002	2,440	63	39	63		456	3
4	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2002	269	7	39	7		50	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from YAM Management	2007	1,698	11	20	98	87	243	9
10	Allocated from YAM Management	2008	117	3	20	12	9	18	10
11	Allocated from YAM Management	2009	516	10	20	43	33	43	11
12									12
13									13
14	Allocated from Extended Care Consulting, 2201 Main LLC	2002	2,016	184	20	184		1,107	14
15	Allocated from Extended Care Consulting, 2201 Main LLC	2003	2,375	217	20	217		1,305	15
16	Allocated from Extended Care Consulting, 2201 Main LLC	2005	118	13	20	13		43	16
17	Allocated from Extended Care Consulting, 2201 Main LLC	2009	21	1	20	1		1	17
18									18
19									19
20	Allocated from Extended Care Consulting, LLC	2007	25		20			3	20
21	Allocated from Extended Care Consulting, LLC	2009	15	1	20	1		1	21
22									22
23									23
24	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2002	222	20	20	20		122	24
25	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2003	262	24	20	24		144	25
26	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2005	13	1	20	1		5	26
27	Allocated from Extended Care Clinical, Inc. 2201 Main LLC	2009	2		20				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 Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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	TOTAL (12H & 12I lines 1 thru 33)	\$ 10,109	\$ 555		\$ 684	\$ 129	\$ 3,541	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 Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 468,056	\$ 2,621	\$ 25,211	\$ 22,590	10	\$ 317,796	71
72	Current Year Purchases	59,146	499	4,530	4,031	10	4,530	72
73	Fully Depreciated Assets	540,888				10	540,888	73
74								74
75	TOTALS	\$ 1,068,090	\$ 3,120	\$ 29,741	\$ 26,621		\$ 863,214	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from YAM Manager	2009	\$ 1,875	\$ 362	\$ 478	\$ 116	5	\$ 760	76
77		Alloc. from EC Clinical	2009	385	77	77		5	227	77
78		Alloc. from EC Consulting	2009	1,722	27	27		5	1,642	78
79		Alloc. from CC Health Systems	2009	539	108	108		5	162	79
80	TOTALS			\$ 4,521	\$ 574	\$ 690	\$ 116		\$ 2,791	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)	\$ 4,480,474	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 52,036	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 149,248	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 97,212	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,756,417	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: Concord Health Properties, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

If NO, see instructions.

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building: <u>1962</u>	<u>134</u>		\$ <u>525,900</u>			3
4	Additions: <u>Storage Rental</u>			<u>66</u>			4
5	<u>Allocated from YAM Management</u>			<u>4,185</u>			5
6	<u>Allocated from Ext. Care Consulting/Care Center Health Systems Inc.</u>			<u>1,465</u>			6
7	TOTAL	134		\$ <u>531,616</u>			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: \$ 4,389 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	<u>Minivan Auto Lease</u>		\$ <u>575.00</u>	\$ <u>5,607</u>	17
18	<u>Allocated from YAM Mgmt.</u>			<u>675</u>	18
19	<u>Allocated from YAM Consult.</u>			<u>4,642</u>	19
20					20
21	TOTAL		\$ <u>575.00</u>	\$ <u>10,924</u>	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.	<u>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</u>	\$ _____

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	113,320	\$		\$	113,320	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				38,081				38,081	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				119,154				119,154	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					145,601			145,601	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <u>See Supplemental</u>						27,121	25,870			52,991	13
14	TOTAL			\$		\$	297,676	\$	171,471	\$	469,147	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

Facility Name & ID Number Concord Extended Care# 0026914Report Period Beginning: 01/01/09

Ending:

12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 84,350	\$ 197,534	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,165,589	1,165,589	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	37,398	67,414	6
7	Other Prepaid Expenses	791	791	7
8	Accounts Receivable (owners or related parties)	403,295	428,872	8
9	Other(specify): <u>See Attached Schedule</u>	149,611	227,451	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,841,034	\$ 2,087,651	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		27,417	13
14	Buildings, at Historical Cost		2,069,821	14
15	Leasehold Improvements, at Historical Cost	98,266	175,308	15
16	Equipment, at Historical Cost	61,940	204,329	16
17	Accumulated Depreciation (book methods)	(19,166)	(1,601,116)	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): <u>See Attached Schedule</u>	332,500	394,249	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 473,540	\$ 1,270,008	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,314,574	\$ 3,357,659	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 352,080	\$ 362,080	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,828	12,828	28
29	Short-Term Notes Payable	400,000	400,000	29
30	Accrued Salaries Payable	205,401	205,401	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,239	12,239	31
32	Accrued Real Estate Taxes(Sch.IX-B)		305,000	32
33	Accrued Interest Payable	1,933	22,180	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	366,944	366,944	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,351,425	\$ 1,686,672	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,749,519	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 3,749,519	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,351,425	\$ 5,436,191	46
47	TOTAL EQUITY(page 18, line 24)	\$ 963,149	\$ (2,078,532)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,314,574	\$ 3,357,659	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,022,206)	1
2	Restatements (describe):		2
3	Equity Adjustment to Rec to Trial Balance	1,012,552	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (9,654)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	512,053	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	(184,250)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Members' Contributions	645,000	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 972,803	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)	\$ 963,149	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care# 0026914Report Period Beginning: 01/01/09Ending: 12/31/09

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	\$ 6,320,953	1
2	Discounts and Allowances for all Levels	(102,094)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,218,859	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	693,669	6
7	Oxygen	373	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 694,042	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	332,500	16
17	Sale of Drugs	146,662	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,299	19
20	Radiology and X-Ray	6,456	20
21	Other Medical Services	27,592	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 524,509	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	69,951	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 69,951	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	5,849	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,849	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,513,210	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,053,257	31
32	Health Care	2,635,885	32
33	General Administration	1,591,492	33
B. Capital Expense			
34	Ownership	1,149,137	34
C. Ancillary Expense			
35	Special Cost Centers	498,021	35
36	Provider Participation Fee	73,365	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,001,157	40
41	Income before Income Taxes (line 30 minus line 40)**	512,053	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 512,053	43

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

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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	939	1,005	\$ 45,710	\$ 45.48	1
2	Assistant Director of Nursing	2,979	3,171	115,185	36.32	2
3	Registered Nurses	12,069	13,043	364,230	27.93	3
4	Licensed Practical Nurses	31,003	33,277	849,298	25.52	4
5	CNAs & Orderlies	74,231	78,996	800,066	10.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,118	8,639	89,708	10.38	8
9	Activity Director	1,979	2,084	26,015	12.48	9
10	Activity Assistants	4,806	5,215	43,434	8.33	10
11	Social Service Workers	959	1,003	17,633	17.58	11
12	Dietician					12
13	Food Service Supervisor	1,499	1,684	31,923	18.96	13
14	Head Cook	2,979	3,297	34,549	10.48	14
15	Cook Helpers/Assistants	12,376	13,037	120,290	9.23	15
16	Dishwashers	2,526	2,774	24,683	8.90	16
17	Maintenance Workers	2,365	2,652	54,251	20.46	17
18	Housekeepers	15,392	16,501	166,432	10.09	18
19	Laundry	7,466	8,161	88,417	10.83	19
20	Administrator	1,801	1,944	79,222	40.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,915	8,511	114,968	13.51	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	1,871	1,871	26,261	14.04	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,276	2,461	34,139	13.87	33
34	TOTAL (lines 1 - 33)	195,549	209,326	\$ 3,126,414 *	\$ 14.94	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	241	\$ 14,286	01-03	35
36	Medical Director	Monthly	23,836	09-03	36
37	Medical Records Consultant	22	1,080	10-03	37
38	Nurse Consultant	350	17,497	10-03	38
39	Pharmacist Consultant	Monthly	3,331	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				44
45	Social Service Consultant	92	4,586	12-03	45
46	Other(specify)				46
47					47
48	<u>See Attached</u>	349	773		48
49	TOTAL (lines 35 - 48)	1,054	\$ 65,389		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

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	
Karen Fogel (01/01 - 04/20)	Administrator		\$ 21,345	Workers' Compensation Insurance	\$ 109,542	IDPH License Fee	\$	
Daniel Johnson (09/08 - Present)	Administrator		25,088	Unemployment Compensation Insurance	52,199	Advertising: Employee Recruitment	3,669	
Gwendolyn Semon (04/23 - 09/04)	Administrator		32,788	FICA Taxes	228,925	Health Care Worker Background Check		
				Employee Health Insurance	71,312	(Indicate # of checks performed <u>222</u>)	2,218	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Fees	5,500	
				Employee Other Benefits	4,852	Dues & Subscriptions	14,669	
				Holiday Expense	600	Allocated from YAM Management	199	
						Allocated from YAM Consulting	1,509	
						See Supplemental Schedule	348	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 79,221	TOTAL (agree to Schedule V, line 22, col.8)	\$ 467,430	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 28,111	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Yosef Meystel			\$ 14,000			\$	Out-of-State Travel	\$
David Berkowitz			25,000					
Steven Blisko			86,124				In-State Travel	
Joseph Blisko			14,375					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 139,499				Seminar Expense	1,604
							Inservice Expense	1,041
							Allocated YAM Management	388
							See Supplemental Schedule	673
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 316,674	TOTAL		\$	TOTAL	\$ 3,706

* 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								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
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

Facility Name & ID Number Concord Extended Care

0026914

Report Period Beginning: 01/01/09

Ending: 12/31/09

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. ILCLTC - \$12,924
- (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. \$ 32,412 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? X YES 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. \$ 73,365
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. \$ Has any meal income been offset against related costs? No Indicate the amount. \$
- (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? None
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.