

		FOR BHF USE					

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**2009**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2009)**

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

<p><b>I. IDPH License ID Number:</b> <u>0050484</u></p> <p><b>Facility Name:</b> <u>Plum Grove Nursing &amp; Rehab Ctr</u></p> <p><b>Address:</b> <u>24 South Plum Grove Road</u> <u>Palatine</u> <u>60067</u>  Number City Zip Code</p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(847)358-0311</u> <b>Fax #</b> <u>(847)358-8875</u></p> <p><b>HFS ID Number:</b> <u>264328936001</u></p> <p><b>Date of Initial License for Current Owners:</b> _____</p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input checked="" type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Steve Lavenda</u> <b>Telephone Number:</b> <u>(847) 236-1111</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>03/01/09</u> to <u>12/31/09</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) <u>Cary C. Buxbaum, C.P.A.</u> (Firm Name &amp; Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> </tr> </table> <p align="right"><b>MAIL TO: BUREAU OF HEALTH FINANCE  ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES  201 S. Grand Avenue East  Springfield, IL 62763-0001 Phone # (217) 782-1630</b></p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>Cary C. Buxbaum, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____							
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>Cary C. Buxbaum, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>							

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plum Grove Nursing & Rehab Ctr

# 0050484 Report Period Beginning: 03/01/09 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	69	Skilled (SNF)	69	21,114	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	69	TOTALS	69	21,114	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 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	2,591	7,692	2,143	12,426	8	
9	SNF/PED					9	
10	ICF	3,578			3,578	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	6,169	7,692	2,143	16,004	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.80%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

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 08/01/2006

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 08/01/2006 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 69 and days of care provided 1,982

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Plum Grove Nursing & Rehab Ctr # 0050484 Report Period Beginning: 03/01/09 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
	<b>A. General Services</b>										
1	Dietary	127,051	8,614	5,174	140,839		140,839		140,839		1
2	Food Purchase		82,020		82,020	(11,246)	70,775	(394)	70,380		2
3	Housekeeping	83,557	8,940		92,497		92,497		92,497		3
4	Laundry	10,529	2,690		13,219		13,219		13,219		4
5	Heat and Other Utilities			39,256	39,256		39,256	284	39,540		5
6	Maintenance	43,423	12,851	43,522	99,796		99,796	12,271	112,067		6
7	Other (specify):*							1,112	1,112		7
8	<b>TOTAL General Services</b>	<b>264,560</b>	<b>115,115</b>	<b>87,952</b>	<b>467,627</b>	<b>(11,246)</b>	<b>456,382</b>	<b>13,273</b>	<b>469,654</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	947,463	76,512	48,519	1,072,494		1,072,494	(25,744)	1,046,750		10
10a	Therapy	21,142	75		21,217		21,217		21,217		10a
11	Activities	52,551	5,380	2,150	60,081		60,081		60,081		11
12	Social Services	36,755		3,327	40,082		40,082	2,427	42,509		12
13	CNA Training										13
14	Program Transportation			1,818	1,818		1,818	758	2,576		14
15	Other (specify):*							3,732	3,732		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,057,911</b>	<b>81,967</b>	<b>64,814</b>	<b>1,204,692</b>		<b>1,204,692</b>	<b>(18,827)</b>	<b>1,185,865</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	72,010		46,754	118,764		118,764	(14,068)	104,696		17
18	Directors Fees										18
19	Professional Services			142,672	142,672		142,672	(86,031)	56,641		19
20	Dues, Fees, Subscriptions & Promotions			37,846	37,846		37,846	(2,735)	35,111		20
21	Clerical & General Office Expenses	32,030	37	118,501	150,568		150,568	(74,148)	76,420		21
22	Employee Benefits & Payroll Taxes			221,193	221,193	11,246	232,439		232,439		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,390	5,390		5,390	467	5,857		24
25	Other Admin. Staff Transportation			380	380		380	411	791		25
26	Insurance-Prop.Liab.Malpractice			46,390	46,390		46,390	250	46,640		26
27	Other (specify):*							6,909	6,909		27
28	<b>TOTAL General Administration</b>	<b>104,040</b>	<b>37</b>	<b>619,126</b>	<b>723,203</b>	<b>11,246</b>	<b>734,449</b>	<b>(168,944)</b>	<b>565,504</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,426,511</b>	<b>197,119</b>	<b>771,892</b>	<b>2,395,522</b>		<b>2,395,522</b>	<b>(174,498)</b>	<b>2,221,024</b>		<b>29</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			8,581	8,581		8,581	74,548	83,129			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,392	11,392		11,392	79,319	90,711			32
33	Real Estate Taxes							79,571	79,571			33
34	Rent-Facility & Grounds			266,038	266,038		266,038	(263,883)	2,155			34
35	Rent-Equipment & Vehicles			4,120	4,120		4,120	2,838	6,958			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			290,131	290,131		290,131	(27,607)	262,524			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		107,081	490,547	597,628		597,628		597,628			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			31,671	31,671		31,671		31,671			42
43	Other (specify):*			1,235	1,235		1,235	(1,235)				43
44	<b>TOTAL Special Cost Centers</b>		107,081	523,453	630,534		630,534	(1,235)	629,299			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,426,511	304,200	1,585,476	3,316,187		3,316,187	(203,340)	3,112,847			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VI. ADJUSTMENT DETAIL**

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

		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	(2,028)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	18,303	30		9
10	Interest and Other Investment Income	(1)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(394)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,602)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(11,670)	21		24
25	Fund Raising, Advertising and Promotional	(2,600)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(134,318)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (134,309)		\$	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)	(69,031)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (69,031)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (203,340)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Plum Grove Nursing & Rehab Ctr

ID# 0050484

Report Period Beginning: 03/01/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

		\$		
1	Discounts Lost	(234)	21	1
2	COPE Dues	(1,014)	20	2
3	Marketing Expenses	(1,235)	43	3
4	Bank Charges	(2,485)	21	4
5	Marketing Fees	(7,329)	21	5
6	Additional R&M	8,625	06	6
7	Non-Allowable Legal Expense	(12,021)	19	7
8	Non-Allowable Office Expense	(61,612)	21	8
9	Building Company Rent Expense	(57,013)	34	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
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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	<b>Total</b>	(134,318)		49

Plum Grove Nursing & Rehab Ctr

ID# 0050484

Report Period Beginning: 03/01/09

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
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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 &amp; ID Number Plum Grove Nursing &amp; Rehab Ctr

# 0050484

Report Period Beginning:

03/01/09

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													1
2	Food Purchase	(394)											(394)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			284									284	5
6	Maintenance	6,597		1,923	3,751								12,271	6
7	Other (specify):*			490	622								1,112	7
8	<b>TOTAL General Services</b>	<b>6,203</b>		<b>2,697</b>	<b>4,373</b>								<b>13,273</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records				(25,744)								(25,744)	10
10a	Therapy													10a
11	Activities													11
12	Social Services				2,427								2,427	12
13	CNA Training													13
14	Program Transportation				758								758	14
15	Other (specify):*				3,732								3,732	15
16	<b>TOTAL Health Care and Programs</b>				<b>(18,827)</b>								<b>(18,827)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			5,248	(19,316)								(14,068)	17
18	Directors Fees													18
19	Professional Services	(12,021)		(69,623)	(4,387)								(86,031)	19
20	Fees, Subscriptions & Promotions	(3,614)		102	777								(2,735)	20
21	Clerical & General Office Expenses	(84,932)		22,674	(11,890)								(74,148)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			200	267								467	24
25	Other Admin. Staff Transportation			345	66								411	25
26	Insurance-Prop.Liab.Malpractice			250									250	26
27	Other (specify):*			5,843	1,066								6,909	27
28	<b>TOTAL General Administration</b>	<b>(100,567)</b>		<b>(34,961)</b>	<b>(33,417)</b>								<b>(168,944)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(94,364)</b>		<b>(32,264)</b>	<b>(47,871)</b>								<b>(174,498)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number Plum Grove Nursing &amp; Rehab Ctr

# 0050484

Report Period Beginning:

03/01/09

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)	
	<b>D. Ownership</b>													
30	Depreciation	18,303	55,762	461	22								74,548	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1)	79,299	21									79,319	32
33	Real Estate Taxes		79,571										79,571	33
34	Rent-Facility & Grounds	(57,013)	(209,025)	2,155									(263,883)	34
35	Rent-Equipment & Vehicles			448	2,390								2,838	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>(38,711)</b>	<b>5,607</b>	<b>3,084</b>	<b>2,412</b>								<b>(27,607)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(1,235)											(1,235)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(1,235)</b>											<b>(1,235)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(134,309)</b>	<b>5,607</b>	<b>(29,180)</b>	<b>(45,458)</b>								<b>(203,340)</b>	<b>45</b>

**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
David Berkowitz	27.5%	See Attached		See Attached		
Joshua Weinstein	5.0%					
Yosef Meystel	27.5%			Plum Grove Realty		Building Co.
Morris Esformes	40.0%					

**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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 266,038	Plum Grove Realty	100.00%	\$	\$ (266,038)	1
2	V	32 Interest Income	217	Plum Grove Realty	100.00%		(217)	2
3	V	34 Rent Expense		Plum Grove Realty	100.00%	57,013	57,013	3
4	V	32 Interest Expense		Plum Grove Realty	100.00%	79,516	79,516	4
5	V	33 Real Estate Taxes		Plum Grove Realty	100.00%	79,571	79,571	5
6	V	30 Depreciation		Plum Grove Realty	100.00%	55,762	55,762	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 266,255			\$ 271,862	\$ * 5,607	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	YAM MANAGEMENT, LLC	100.00%	\$ 284	\$	284	15
16	V	6 REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	1,923		1,923	16
17	V	7 EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	490		490	17
18	V	17 ADMIN. - RELATED		YAM MANAGEMENT, LLC	100.00%	2,448		2,448	18
19	V	17 ADMIN. - NON RELATED		YAM MANAGEMENT, LLC	100.00%	2,800		2,800	19
20	V	19 PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	1,597		1,597	20
21	V	20 FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	102		102	21
22	V	21 CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	22,674		22,674	22
23	V	24 SEMINARS		YAM MANAGEMENT, LLC	100.00%	200		200	23
24	V	25 AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	345		345	24
25	V	26 INSURANCE		YAM MANAGEMENT, LLC	100.00%	250		250	25
26	V	27 EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	5,843		5,843	26
27	V	30 DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	461		461	27
28	V	32 INTEREST		YAM MANAGEMENT, LLC	100.00%	21		21	28
29	V	34 RENT		YAM MANAGEMENT, LLC	100.00%	2,155		2,155	29
30	V	35 AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	348		348	30
31	V	35 EQUIPMENT RENTAL		YAM MANAGEMENT, LLC	100.00%	100		100	31
32	V								32
33	V	19 BOOKKEEPING FEES	47,220	YAM MANAGEMENT, LLC	100.00%			(47,220)	33
34	V	19 ACCOUNTING	24,000	YAM MANAGEMENT, LLC	100.00%			(24,000)	34
35	V	17 MANAGEMENT FEES		YAM MANAGEMENT, LLC	100.00%				35
36	V								36
37	V								37
38	V								38
39	Total		\$ 71,220			\$ 42,040	\$ *	(29,180)	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%	\$ 3,751	\$	3,751	15
16	V	7 EMP. BEN. GEN. SERV.		YAM CONSULTING, LLC	100.00%	622		622	16
17	V	10 NURSING SALARY		YAM CONSULTING, LLC	100.00%	20,288		20,288	17
18	V	12 SOCIAL SERVICES SALARY		YAM CONSULTING, LLC	100.00%	2,427		2,427	18
19	V	14 PROGRAM TRANSPORTATION		YAM CONSULTING, LLC	100.00%	758		758	19
20	V	15 EMP. BEN. HEALTHCARE		YAM CONSULTING, LLC	100.00%	3,732		3,732	20
21	V	17 ADMIN. - NON RELEATED		YAM CONSULTING, LLC	100.00%	2,884		2,884	21
22	V	19 PROFESSIONAL FEES		YAM CONSULTING, LLC	100.00%	275		275	22
23	V	20 FEES, SUBSCRIPTIONS		YAM CONSULTING, LLC	100.00%	777		777	23
24	V	21 CLERICAL & GENERAL		YAM CONSULTING, LLC	100.00%	4,010		4,010	24
25	V	24 SEMINARS		YAM CONSULTING, LLC	100.00%	267		267	25
26	V	25 AUTO AND TRAVEL		YAM CONSULTING, LLC	100.00%	66		66	26
27	V	27 EMP. BEN.-GEN. ADMIN.		YAM CONSULTING, LLC	100.00%	1,066		1,066	27
28	V	30 DEPRECIATION		YAM CONSULTING, LLC	100.00%	22		22	28
29	V	35 AUTO RENTAL		YAM CONSULTING, LLC	100.00%	2,390		2,390	29
30	V								30
31	V								31
32	V								32
33	V	10 NURSING CONSULTING	1,632					(1,632)	33
34	V	10 ADMIN. CONSULTING	44,400					(44,400)	34
35	V	17 DIR. OF OPERATIONS CONSULT	22,200					(22,200)	35
36	V	19 DATA PROCESSING FEES	4,662					(4,662)	36
37	V	21 MARKETING	15,900					(15,900)	37
38	V								38
39	Total		\$ 88,794			\$ 43,336	\$ *	(45,458)	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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Plum Grove Nursing & Rehab Ctr # 0050484 Report Period Beginning: 03/01/09 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	Shareholder	Administrative	27.50%	See Attached	1.60	4.00%	Mgmt Fees	\$ 6,000	17-3	1
2	David Berkowitz	Shareholder	Administrative	27.50%	See Attached			Mgmt Fees	11,500	17-3	2
3	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.80	2.00%	Alloc. Salary	1,504	17-7	3
4	Joel Meystel	Relative	Administrative	0.00%	See Attached	0.80	4.00%	Alloc. Salary	943	17-7	4
5	Joshua Weinstein	Shareholder	Administrative	5.00%	See Attached	1.60	4.00%	Fees/ Alc. Sal.	12,737	17-3; 17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 32,684		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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Plum Grove Nursing & Rehab Ctr # 0050484 Report Period Beginning: 03/01/09 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 Plum Grove Nursing & Rehab Ctr

# 0050484

Report Period Beginning:

03/01/09

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	\$ 21,114	\$ 284	1	
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	516,637	12	47,049	41,077	21,114	1,923	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	516,637	12	11,995		21,114	490	3
4	17	ADMIN. - RELATED	AVAIL. BED DAYS	516,637	12	59,890	59,890	21,114	2,448	4
5	17	ADMIN. - NON RELATED	AVAIL. BED DAYS	516,637	12	68,520	68,520	21,114	2,800	5
6	19	PROFESSIONAL FEES	AVAIL. BED DAYS	516,637	12	39,084		21,114	1,597	6
7	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	516,637	12	2,504		21,114	102	7
8	21	CLERICAL & GENERAL	AVAIL. BED DAYS	516,637	12	554,814	499,630	21,114	22,674	8
9	24	SEMINARS	AVAIL. BED DAYS	516,637	12	4,893		21,114	200	9
10	25	AUTO AND TRAVEL	AVAIL. BED DAYS	516,637	12	8,444		21,114	345	10
11	26	INSURANCE	AVAIL. BED DAYS	516,637	12	6,121		21,114	250	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	516,637	12	142,965		21,114	5,843	12
13	30	DEPRECIATION	AVAIL. BED DAYS	516,637	12	11,270		21,114	461	13
14	32	INTEREST	AVAIL. BED DAYS	516,637	12	513		21,114	21	14
15	34	RENT	AVAIL. BED DAYS	516,637	12	52,725		21,114	2,155	15
16	35	AUTO RENTAL	AVAIL. BED DAYS	516,637	12	8,509		21,114	348	16
17	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	516,637	12	2,458		21,114	100	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,028,697	\$ 669,116	\$ 42,040		25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plum Grove Nursing & Rehab Ctr

# 0050484

Report Period Beginning:

03/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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	6	DIETARY	AVAIL. BED DAYS	516,637	12	\$ 91,773	\$ 89,792	21,114	\$ 3,751	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	516,637	12	15,208		21,114	622	2
3	10	NURSING SALARY	AVAIL. BED DAYS	516,637	12	496,414	496,414	21,114	20,288	3
4	12	SOCIAL SERVICES SALARY	AVAIL. BED DAYS	516,637	12	59,382	59,382	21,114	2,427	4
5	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	516,637	12	18,550		21,114	758	5
6	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	516,637	12	91,325		21,114	3,732	6
7	17	ADMIN. - NON RELEATED	AVAIL. BED DAYS	516,637	12	70,560	70,560	21,114	2,884	7
8	19	PROFESSIONAL FEES	AVAIL. BED DAYS	516,637	12	6,724		21,114	275	8
9	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	516,637	12	19,007		21,114	777	9
10	21	CLERICAL & GENERAL	AVAIL. BED DAYS	516,637	12	98,110	79,705	21,114	4,010	10
11	24	SEMINARS	AVAIL. BED DAYS	516,637	12	6,543		21,114	267	11
12	25	AUTO AND TRAVEL	AVAIL. BED DAYS	516,637	12	1,616		21,114	66	12
13	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	516,637	12	26,075		21,114	1,066	13
14	30	DEPRECIATION	AVAIL. BED DAYS	516,637	12	539		21,114	22	14
15	35	AUTO RENTAL	AVAIL. BED DAYS	516,637	12	58,491		21,114	2,390	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		\$ 43,336	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plum Grove Nursing & Rehab Ctr

# 0050484

Report Period Beginning:

03/01/09

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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plum Grove Nursing & Rehab Ctr # 0050484 Report Period Beginning: 03/01/09 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 Plum Grove Nursing & Rehab Ctr

# 0050484

Report Period Beginning:

03/01/09

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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plum Grove Nursing & Rehab Ctr # 0050484 Report Period Beginning: 03/01/09 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 Plum Grove Nursing & Rehab Ctr

# 0050484

Report Period Beginning:

03/01/09

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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plum Grove Nursing & Rehab Ctr

# 0050484

Report Period Beginning:

03/01/09

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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plum Grove Nursing & Rehab Ctr

# 0050484 Report Period Beginning: 03/01/09 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 &amp; ID Number

Plum Grove Nursing &amp; Rehab Ctr

# 0050484

Report Period Beginning:

03/01/09

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		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
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1	Plum Grove Realty		X	Mortgage			\$	\$ 2,325,855			\$ 79,516	1								
2												2								
3												3								
4												4								
5	See Supplemental Schedule											5								
	<b>Working Capital</b>																			
6	First Equity Bank		X	Line of Credit				275,000			9,516	6								
7	First Equity Bank		X	Insurance Financing				46,430			1,876	7								
8	See Supplemental Schedule										21	8								
9	TOTAL Facility Related						\$	\$ 2,647,285			\$ 90,929	9								
	<b>B. Non-Facility Related*</b>																			
10	Interest Income		X								(1)	10								
11	Interest Income (Bldg. Co. )		X								(217)	11								
12												12								
13	See Supplemental Schedule											13								
14	TOTAL Non-Facility Related						\$	\$			\$ (218)	14								
15	TOTALS (line 9+line14)						\$	\$ 2,647,285			\$ 90,711	15								

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Plum Grove Nursing & Rehab Ctr

# 0050484

Report Period Beginning:

03/01/09

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
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1							\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
6												6								
7	<b>TOTAL Long-Term</b>																			
	<b>Working Capital</b>																			
8	Allocated From Yam Management	X					\$	\$			\$	21								
9												9								
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Working Capital</b>																			
	<b>B. Non-Facility Related*</b>																			
15							\$	\$			\$	15								
16												16								
17												17								
18												18								
19												19								
20	<b>TOTAL Non-Facility Related</b>																			

\* 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 Plum Grove Nursing & Rehab Ctr

# 0050484

Report Period Beginning:

03/01/09

Ending:

12/31/09

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 23,500 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2009</u>	<u>\$ 120,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 120,000</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plum Grove Nursing & Rehab Ctr

# 0050484

Report Period Beginning:

03/01/09

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		
	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
	<b>Improvement Type**</b>										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

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)	967,220	55,762		27,635	(28,127)	27,635	67
68	Related Party Allocations (Pages 12H & 12I)	1,201	13		78	65	157	68
69	Financial Statement Depreciation		3,072			(3,072)		69
70	TOTAL (lines 4 thru 69)	\$ 968,421	\$ 58,847		\$ 27,713	\$ (31,135)	\$ 27,792	70

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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 968,421	\$ 58,847		\$ 27,713	\$ (31,135)	\$ 27,792	1
2	Fire Sprinkler	2009	125,779		20	6,289	6,289	6,289	2
3	Door Alarm	2009	6,447		20	322	322	322	3
4	Fire Alarm	2009	12,068		20	603	603	603	4
5	Shunt Trip For Elevator	2009	3,800		20	190	190	190	5
6	Outside Wiring With Molding	2009	3,920		20	196	196	196	6
7	Elevator Shunt Relay & Supervisory Relay	2009	2,786		20	139	139	139	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,123,222	\$ 58,847		\$ 35,453	\$ (23,394)	\$ 35,532	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		\$ 1,123,222	\$ 58,847		\$ 35,453	\$ (23,394)	\$ 35,532	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)	\$ 1,123,222	\$ 58,847		\$ 35,453	\$ (23,394)	\$ 35,532	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,123,222	\$ 58,847		\$ 35,453	\$ (23,394)	\$ 35,532	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)		\$ 1,123,222	\$ 58,847		\$ 35,453	\$ (23,394)	\$ 35,532	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 1,123,222	\$ 58,847		\$ 35,453	\$ (23,394)	\$ 35,532	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		\$ 1,123,222	\$ 58,847		\$ 35,453	\$ (23,394)	\$ 35,532	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Building Company Information</b>								1
2	<b>Buildings:</b>								2
3	Plum Grove Realty, LLC	1961	967,220	55,762	35	27,635	(28,127)	27,635	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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)	\$ 967,220	\$ 55,762		\$ 27,635	\$ (28,127)	\$ 27,635	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Related Party Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	Allocated From YAM Management	2007	875	6	20	50	44	125	9
10	Allocated From YAM Management	2008	60	2	20	6	4	10	10
11	Allocated From YAM Management	2009	266	5	20	22	17	22	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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)	\$ 1,201	\$ 13		\$ 78	\$ 65	\$ 157	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Plum Grove Nursing & Rehab Ctr

# 0050484

Report Period Beginning:

03/01/09

Ending:

12/31/09

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	\$ 1,182	\$ 50	\$ 136	\$ 86	10	\$ 313	71
72	Current Year Purchases	377,637	4,948	37,758	32,810	10	37,758	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 378,819	\$ 4,998	\$ 37,894	\$ 32,896		\$ 38,071	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	Facility	2009 GMC Savana	2009	\$ 47,683	\$ 795	\$ 9,537	\$ 8,742	5	\$ 9,537	76
77		Allocated From YAM Managemen	2009	966	186	246	60	5	391	77
78										78
79										79
80	TOTALS			\$ 48,649	\$ 981	\$ 9,783	\$ 8,802		\$ 9,928	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)	\$ 1,670,690	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 64,826	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 83,130	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 18,303	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 83,531	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	Patio Enclosures	\$ 11,354	92
93	ECS Software	13,945	93
94			94
95		\$ 25,299	95

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	<u>Allocated From YAM Management</u>				<u>2,155</u>			5
6								6
7	TOTAL				\$ <u>2,155</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: \$ 4,220 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>Allocated From YAM Management</u>		\$	\$ <u>348</u>	17
18	<u>Allocated From YAM Consulting</u>			<u>2,390</u>	18
19					19
20					20
21	TOTAL		\$	\$ <u>2,738</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. \_\_\_\_\_/2009 \$ \_\_\_\_\_

13. \_\_\_\_\_/2010 \$ \_\_\_\_\_

14. \_\_\_\_\_/2011 \$ \_\_\_\_\_

\* 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	2		
		Drop-outs	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

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

- (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	\$		\$	240,240	\$		\$	240,240	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				65,817				65,817	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				184,490				184,490	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					103,202			103,202	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <b>See Supplemental</b>							3,879			3,879	13
14	<b>TOTAL</b>			\$		\$	490,547	\$	107,081	\$	597,628	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 Plum Grove Nursing & Rehab Ctr

# 0050484

Report Period Beginning: 03/01/09

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*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 25,168	\$ 57,119	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	540,322	540,322	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,774	16,774	6
7	Other Prepaid Expenses	1,743	1,743	7
8	Accounts Receivable (owners or related parties)	300,000	1,236,907	8
9	Other(specify): <u>See Attached Schedule</u>	129,542	296,014	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 1,013,549</b>	<b>\$ 2,148,879</b>	<b>10</b>
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		120,000	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	155,597	1,122,817	15
16	Equipment, at Historical Cost	70,106	432,914	16
17	Accumulated Depreciation (book methods)	(8,581)	(64,343)	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>	995,370	995,370	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 1,212,492</b>	<b>\$ 2,606,758</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 2,226,041</b>	<b>\$ 4,755,637</b>	<b>25</b>

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 451,211	\$ 451,211	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	831	831	28
29	Short-Term Notes Payable	321,430	321,430	29
30	Accrued Salaries Payable	137,504	137,504	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,619	4,619	31
32	Accrued Real Estate Taxes(Sch.IX-B)	89,025	195,854	32
33	Accrued Interest Payable	319	2,839	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	1,104,138	1,204,138	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 2,109,077</b>	<b>\$ 2,318,426</b>	<b>38</b>
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,325,855	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$</b>	<b>\$ 2,325,855</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 2,109,077</b>	<b>\$ 4,644,281</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 116,964</b>	<b>\$ 111,356</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 2,226,041</b>	<b>\$ 4,755,637</b>	<b>48</b>

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	186,964	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(70,000)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 116,964	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 116,964	<b>24</b> *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Plum Grove Nursing &amp; Rehab Ctr

# 0050484

Report Period Beginning: 03/01/09

Ending: 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,490,704	1
2	Discounts and Allowances for all Levels	(120,190)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,370,514</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,012,039	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,012,039</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	98,151	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,080	19
20	Radiology and X-Ray	1,105	20
21	Other Medical Services	11,261	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 120,597</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 1</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<a href="#">See Supplemental Schedule</a>		28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 3,503,151</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	467,627	31
32	Health Care	1,204,692	32
33	General Administration	723,203	33
<b>B. Capital Expense</b>			
34	Ownership	290,131	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	598,863	35
36	Provider Participation Fee	31,671	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 3,316,187</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>186,964</b>	<b>41</b>
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 186,964</b>	<b>43</b>

\* 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 Plum Grove Nursing & Rehab Ctr

# 0050484

Report Period Beginning:

03/01/09

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	1,767	1,997	\$ 65,059	\$ 32.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,441	6,108	180,639	29.57	3
4	Licensed Practical Nurses	9,671	10,152	271,228	26.72	4
5	CNAs & Orderlies	29,928	33,021	419,139	12.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,516	1,666	21,142	12.69	8
9	Activity Director	160	160	3,200	20.00	9
10	Activity Assistants	3,528	3,924	49,351	12.58	10
11	Social Service Workers	1,431	1,589	36,755	23.13	11
12	Dietician					12
13	Food Service Supervisor	1,562	1,749	43,630	24.95	13
14	Head Cook	3,650	3,971	43,411	10.93	14
15	Cook Helpers/Assistants	3,844	4,075	40,010	9.82	15
16	Dishwashers					16
17	Maintenance Workers	1,695	1,749	43,423	24.83	17
18	Housekeepers	7,528	8,189	83,557	10.20	18
19	Laundry	984	1,063	10,529	9.90	19
20	Administrator	1,741	1,819	72,010	39.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,624	1,749	32,030	18.31	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	370	370	11,398	30.81	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	76,440	83,351	\$ 1,426,511 *	\$ 17.11	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	94	\$ 5,174	01-03	35
36	Medical Director	Monthly	9,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	718	44,792	10-03	38
39	Pharmacist Consultant	Monthly	3,727	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	40	2,150	11-03	44
45	Social Service Consultant	63	3,327	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	915	\$ 68,170		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	
Lisa Ulbert	Administrator	0.00%	\$ 72,010	Workers' Compensation Insurance	\$ 40,460	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	16,086	Advertising: Employee Recruitment	22,651	
				FICA Taxes	102,539	Health Care Worker Background Check	770	
				Employee Health Insurance	60,163	(Indicate # of checks performed 77 )		
				Employee Meals	11,246	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Permits	473	
				Life Insurance	417	Dues & Subscriptions	9,343	
				Other Employee Benefits	1,528	Advertising & Promotions	2,600	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 72,010					
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
Management Fees- David Berkowitz			\$ 11,500				Out-of-State Travel	\$
Management Fees- Yosef Meystel			6,000					
Management Fees- Josh Weinstein			7,053				In-State Travel	
YAM Consulting Director of Operations Consult.			22,200					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 46,753				Seminar Expense	5,390
(Attach a copy of any management service agreement)							Allocated From YAM Management	200
							Allocated From YAM Consulting	267
C. Professional Services				TOTAL			Entertainment Expense ( )	
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
Frost, Ruttenberg & Rothblatt	Accounting		\$ 4,608				TOTAL	
YAM Management	Bookkeeping		47,220				\$ 5,857	
YAM Management	Accounting		24,000					
Personnel Planners	Unemployment Consult		1,226					
See Attached	Legal		37,754					
Eldercare Consulting	Geriatric Consulting		3,838					
YAM Consulting	Data Processing		4,662					
Health Data Systems	Data Processing		7,790					
E-Health Data	Data Processing		4,431					
American Data	Data Processing		5,343					
SAS Architects & Planners	Architects		1,800					
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 142,672					

\* 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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$							
2																				
3																				
4																				
5																				
6																				
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16																				
17																				
18																				
19																				
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$							

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Plum Grove Nursing &amp; Rehab Ctr

# 0050484

Report Period Beginning:

03/01/09

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. Illinois Council on LTC \$4,580
- (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. \$ 12,084 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 31,671  
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. \$ 11,246 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ 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.