



Facility Name & ID Number North Church Nursing And Rehab.

# 0051094 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>113</u>	Skilled (SNF)	<u>113</u>	<u>41,245</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>113</u>	TOTALS	<u>113</u>	<u>41,245</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	<u>22,118</u>	<u>32</u>	<u>3,619</u>	<u>25,769</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>22,118</u>	<u>32</u>	<u>3,619</u>	<u>25,769</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.48%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 9/1/2010

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 9/1/2010 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 23 and days of care provided 2,018

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number North Church Nursing And Rehab. # 0051094 Report Period Beginning: 01/01/11 Ending: 12/31/11

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	118,299	12,206	5,859	136,364		136,364	2,109	138,473		1
2	Food Purchase		105,172		105,172		105,172	(1)	105,171		2
3	Housekeeping	82,915	13,402		96,317		96,317		96,317		3
4	Laundry	26,910	6,536		33,446		33,446		33,446		4
5	Heat and Other Utilities			65,139	65,139		65,139	913	66,052		5
6	Maintenance	65,915	4,124	26,643	96,682		96,682	12,822	109,504		6
7	Other (specify):*							1,065	1,065		7
8	<b>TOTAL General Services</b>	<b>294,039</b>	<b>141,440</b>	<b>97,641</b>	<b>533,120</b>		<b>533,120</b>	<b>16,908</b>	<b>550,028</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			15,000	15,000		15,000		15,000		9
10	Nursing and Medical Records	1,011,490	47,378	35,394	1,094,262		1,094,262	2,606	1,096,868		10
10a	Therapy	27,538			27,538		27,538		27,538		10a
11	Activities	32,419	1,160	1,769	35,348		35,348		35,348		11
12	Social Services	11,874		4,443	16,317		16,317		16,317		12
13	CNA Training										13
14	Program Transportation							2,301	2,301		14
15	Other (specify):*							4,467	4,467		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,083,321</b>	<b>48,538</b>	<b>56,606</b>	<b>1,188,465</b>		<b>1,188,465</b>	<b>9,374</b>	<b>1,197,839</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	75,977		44,000	119,977		119,977	191	120,168		17
18	Directors Fees										18
19	Professional Services			111,169	111,169		111,169	(77,085)	34,084		19
20	Dues, Fees, Subscriptions & Promotions			43,972	43,972		43,972	(10,962)	33,010		20
21	Clerical & General Office Expenses	55,545	2,682	86,142	144,369		144,369	15,479	159,848		21
22	Employee Benefits & Payroll Taxes			252,566	252,566		252,566		252,566		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,940	2,940		2,940	(1,120)	1,820		24
25	Other Admin. Staff Transportation			11,641	11,641		11,641	2,103	13,744		25
26	Insurance-Prop.Liab.Malpractice			52,160	52,160		52,160	1,270	53,430		26
27	Other (specify):*							15,999	15,999		27
28	<b>TOTAL General Administration</b>	<b>131,522</b>	<b>2,682</b>	<b>604,590</b>	<b>738,794</b>		<b>738,794</b>	<b>(54,125)</b>	<b>684,669</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,508,882</b>	<b>192,660</b>	<b>758,837</b>	<b>2,460,379</b>		<b>2,460,379</b>	<b>(27,843)</b>	<b>2,432,536</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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			22,088	22,088		22,088	41,862	63,950			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,012	13,012		13,012	113,503	126,515			32
33	Real Estate Taxes			33,412	33,412		33,412	1,554	34,966			33
34	Rent-Facility & Grounds			154,289	154,289		154,289	(154,289)				34
35	Rent-Equipment & Vehicles			17,970	17,970		17,970	5,188	23,158			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			240,771	240,771		240,771	7,818	248,589			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		71,531	290,796	362,327		362,327		362,327			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,868	61,868		61,868		61,868			42
43	Other (specify):*			140,291	140,291		140,291	(140,291)				43
44	<b>TOTAL Special Cost Centers</b>		71,531	492,955	564,486		564,486	(140,291)	424,195			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,508,882	264,191	1,492,563	3,265,636		3,265,636	(160,316)	3,105,320			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Church Nursing And Rehab.

# 0051094

Report Period Beginning:

01/01/11

Ending:

12/31/11

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(113,770)	30		9
10	Interest and Other Investment Income	(20)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,430)	21		18
19	Entertainment	(1,961)	24		19
20	Contributions	(9,050)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(35,756)	21		24
25	Fund Raising, Advertising and Promotional	(2,394)	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	(99,946)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (264,328)		\$	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)	104,012		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 104,012		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (160,316)		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	52

SEE ACCOUNTANTS' COMPILATION REPORT

North Church Nursing And Rehab.

ID# 0051094

Report Period Beginning: 01/01/11

Ending: 12/31/11

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Bank Charges	\$ (935)	21	1
2	Theft/Damage Loss	(3,267)	21	2
3	Marketing Fees	(16,902)	43	3
4	Jury Duty Income	(46)	21	4
5	Prior Period Real Estate Tax	(191)	33	5
6	Additional R&M	11,270	06	6
7	Non-Allowable Expense	(84,838)	43	7
8	Misc. Income	(3,070)	21	8
9	Non-Allowable Legal	(1,967)	19	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
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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>	(99,946)		49

North Church Nursing And Rehab.

ID# 0051094

Report Period Beginning: 01/01/11

Ending: 12/31/11

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

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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66			17
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83			34
84			35
85			36
86			37
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90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number North Church Nursing And Rehab.# 0051094

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				2,109								2,109	1
2	Food Purchase	(1)											(1)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			913									913	5
6	Maintenance	11,270		1,552									12,822	6
7	Other (specify):*			110	955								1,065	7
8	<b>TOTAL General Services</b>	<b>11,269</b>		<b>2,575</b>	<b>3,064</b>								<b>16,908</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records				2,606								2,606	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation				2,301								2,301	14
15	Other (specify):*				4,467								4,467	15
16	<b>TOTAL Health Care and Programs</b>				<b>9,374</b>								<b>9,374</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			21,422	(21,231)								191	17
18	Directors Fees													18
19	Professional Services	(1,967)		(78,549)	3,121	310							(77,085)	19
20	Fees, Subscriptions & Promotions	(11,444)		394	51	37							(10,962)	20
21	Clerical & General Office Expenses	(44,504)		53,488	6,435	60							15,479	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,961)		609	232								(1,120)	24
25	Other Admin. Staff Transportation			1,772	331								2,103	25
26	Insurance-Prop.Liab.Malpractice			1,270									1,270	26
27	Other (specify):*			14,179	1,820								15,999	27
28	<b>TOTAL General Administration</b>	<b>(59,876)</b>		<b>14,585</b>	<b>(9,241)</b>	<b>407</b>							<b>(54,125)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(48,607)</b>		<b>17,160</b>	<b>3,197</b>	<b>407</b>							<b>(27,843)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number North Church Nursing And Rehab.# 0051094

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

	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	(113,770)	151,500	997	40	3,095							41,862	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(20)	110,154	60		3,309							113,503	32
33	Real Estate Taxes	(191)		2,788		(1,043)							1,554	33
34	Rent-Facility & Grounds		(141,539)	(3,382)		(9,368)							(154,289)	34
35	Rent-Equipment & Vehicles			1,470	3,718								5,188	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>(113,981)</b>	<b>120,115</b>	<b>1,933</b>	<b>3,758</b>	<b>(4,007)</b>							<b>7,818</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):*	(101,740)			(38,551)								(140,291)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(101,740)</b>			<b>(38,551)</b>								<b>(140,291)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(264,328)	120,115	19,093	(31,596)	(3,600)							(160,316)	45

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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 Rent Income	\$ 141,539	Centralia Property, LLC	100.00%	\$	(141,539)	1
2	V	32 Interest Expense		Centralia Property, LLC	100.00%	110,154	110,154	2
3	V	30 Depreciation		Centralia Property, LLC	100.00%	151,500	151,500	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 141,539			\$ 261,654	\$ * 120,115	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 UTILITIES	\$	YAM MANAGEMENT, LLC	100.00%	\$ 913	\$ 913	15
16	V	6 REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	1,552	1,552	16
17	V	7 EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	110	110	17
18	V	17 ADMINISTRATIVE		YAM MANAGEMENT, LLC	100.00%	21,422	21,422	18
19	V	19 PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	1,599	1,599	19
20	V	20 FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	394	394	20
21	V	21 CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	53,488	53,488	21
22	V	24 SEMINARS		YAM MANAGEMENT, LLC	100.00%	609	609	22
23	V	25 AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	1,772	1,772	23
24	V	26 INSURANCE		YAM MANAGEMENT, LLC	100.00%	1,270	1,270	24
25	V	27 EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	14,179	14,179	25
26	V	30 DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	997	997	26
27	V	32 INTEREST		YAM MANAGEMENT, LLC	100.00%	60	60	27
28	V	33 REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%	2,788	2,788	28
29	V	34 RENT		YAM MANAGEMENT, LLC	100.00%	9,368	9,368	29
30	V	35 AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	1,086	1,086	30
31	V	35 EQUIPMENT RENTAL		YAM MANAGEMENT, LLC	100.00%	384	384	31
32	V							32
33	V							33
34	V							34
35	V	19 BOOKKEEPING FEES	68,148	YAM MANAGEMENT, LLC	100.00%		(68,148)	35
36	V	19 ACCOUNTING	12,000	YAM MANAGEMENT, LLC	100.00%		(12,000)	36
37	V	34 RENT	12,750	YAM MANAGEMENT, LLC	100.00%		(12,750)	37
38	V							38
39	Total		\$ 92,898			\$ 111,991	\$ * 19,093	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	<u>1</u> <u>DIETARY</u>	\$	<u>YAM CONSULTING, LLC</u>	100.00%	\$ 7,968	\$ 7,968
16	V	<u>7</u> <u>EMP. BEN. GEN. SERV.</u>		<u>YAM CONSULTING, LLC</u>	100.00%	955	955
17	V	<u>10</u> <u>NURSING SALARY</u>		<u>YAM CONSULTING, LLC</u>	100.00%	35,885	35,885
18	V	<u>14</u> <u>PROGRAM TRANSPORTATION</u>		<u>YAM CONSULTING, LLC</u>	100.00%	2,301	2,301
19	V	<u>15</u> <u>EMP. BEN. HEALTHCARE</u>		<u>YAM CONSULTING, LLC</u>	100.00%	4,467	4,467
20	V	<u>17</u> <u>ADMINISTRATIVE</u>		<u>YAM CONSULTING, LLC</u>	100.00%	11,769	11,769
21	V	<u>19</u> <u>PROFESSIONAL FEES</u>		<u>YAM CONSULTING, LLC</u>	100.00%	3,121	3,121
22	V	<u>20</u> <u>FEES, SUBSCRIPTIONS</u>		<u>YAM CONSULTING, LLC</u>	100.00%	51	51
23	V	<u>21</u> <u>CLERICAL &amp; GENERAL</u>		<u>YAM CONSULTING, LLC</u>	100.00%	6,435	6,435
24	V	<u>24</u> <u>SEMINARS</u>		<u>YAM CONSULTING, LLC</u>	100.00%	232	232
25	V	<u>25</u> <u>AUTO AND TRAVEL</u>		<u>YAM CONSULTING, LLC</u>	100.00%	331	331
26	V	<u>27</u> <u>EMP. BEN.-GEN. ADMIN.</u>		<u>YAM CONSULTING, LLC</u>	100.00%	1,820	1,820
27	V	<u>30</u> <u>DEPRECIATION</u>		<u>YAM CONSULTING, LLC</u>	100.00%	40	40
28	V	<u>35</u> <u>AUTO RENTAL</u>		<u>YAM CONSULTING, LLC</u>	100.00%	3,718	3,718
29	V	<u>0</u>					
30	V						
31	V						
32	V						
33	V	<u>01</u> <u>DIETICIAN CONSULTING</u>	5,859	<u>YAM CONSULTING, LLC</u>	100.00%		(5,859)
34	V	<u>10</u> <u>NURSE CONSULTING</u>	33,279	<u>YAM CONSULTING, LLC</u>	100.00%		(33,279)
35	V	<u>17</u> <u>DIR. OF OPERATIONS CONSULT</u>	33,000	<u>YAM CONSULTING, LLC</u>	100.00%		(33,000)
36	V						
37	V	<u>43</u> <u>MARKETING</u>	38,551	<u>YAM CONSULTING, LLC</u>	100.00%		(38,551)
38	V						
39	Total		\$ 110,689			\$ 79,093	\$ * (31,596)

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

Facility Name & ID Number North Church Nursing And Rehab.

# 0051094

Report Period Beginning: 01/01/11

Ending: 12/31/11

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19 PROFESSIONAL FEES	\$	8131 N. MONTICELLO, LLC	100.00%	\$ 310	\$	310	15
16	V	20 DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		37		37	16
17	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC		60		60	17
18	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC		3,095		3,095	18
19	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC		3,309		3,309	19
20	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		1,745		1,745	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34 RENT	9,368	8131 N. MONTICELLO, LLC				(9,368)	26
27	V	33 REAL ESTATE TAXES	2,788	8131 N. MONTICELLO, LLC				(2,788)	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		\$ 12,156			\$ 8,556	\$ *	(3,600)	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: 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.

**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: 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: 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.

Facility Name & ID Number

North Church Nursing And Rehab.

# 0051094

Report Period Beginning:

01/01/11

Ending:

12/31/11

**VII. RELATED PARTIES**

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ML EQUITY PARTNERS LLC	5.000%	BERKSHIRE NURSING & REHAB CENTER,LLC	FOREST PARK	YAM MANAGEMENT	SKOKIE	MANAGEMENT CO.	1
2	MARTIN LOEB	2.000%	CONCORD NURSING AND REHABILITATION CENTER,LLC	OAK LAWN	YAM CONSULTING	SKOKIE	CONSULTING CO.	2
3	HOWARD SUSS	5.000%	DOLTON NURSING & REHAB,LLC	DOLTON	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDIN	3
4	DAVID BERKOWITZ	36.500%	EVANSTON NURSING & REHAB CENTER, LLC	EVANSTON	CENTRALIA PROPERTY, LLC	SKOKIE	BUILDING CO.	4
5	DECLARATION OF TRUST OF YOSEF	34.500%	EXCEPTIONAL CARE, LLC	BURBANK				5
6	JAY MEYSEL TRUST	4.000%	FAIRVIEW CARE CENTER OF JOLIET,LLC	JOLIET				6
7	STEVEN TUROFSKY	1.000%	HIGHLAND PARK NURSING AND REHAB CENTER, LLC	HIGHWOOD				7
8	FREDERICK S. FRANKEL	1.000%	JACKSONVILLE CARE CENTER	JACKSONVILLE				8
9	CHRISTINA INOFRE	1.000%	LITCHFIELD CARE CENTER,LLC	LITCHFIELD				9
10	42170 LIMITED PARTNERSHIP	2.500%	NORTH CHURCH NURSING & REHAB,LLC	JACKSONVILLE				10
11	1219 LIMITED PARTNERSHIP	2.500%	PLAZA NURSING AND REHAB CENTER,LLC	MIDLOTHIAN				11
12	906 LLC	2.500%	PLUM GROVE NURSING AND REHAB,LLC	PALATINE				12
13	CONGREGATION OF TIFERES AVROHOM	2.500%	RIVIERA CARE CENTER,LLC	CHICAGO HEIGHTS				13
14			ROCKFORD NUR. & REHAB	ROCKFORD				14
15			SPRINGFIELD CARE CENTER,LLC	SPRINGFIELD				15
16			LINCOLN REHABILITATION CENTER, LLC	DECATUR				16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			#N/A	#N/A	#N/A	#N/A	#N/A	1
2			#N/A	#N/A	#N/A	#N/A	#N/A	2
3			#N/A	#N/A	#N/A	#N/A	#N/A	3
4			#N/A	#N/A	#N/A	#N/A	#N/A	4
5			#N/A	#N/A	#N/A	#N/A	#N/A	5
6			#N/A	#N/A	#N/A	#N/A	#N/A	6
7			#N/A	#N/A	#N/A	#N/A	#N/A	7
8			#N/A	#N/A	#N/A	#N/A	#N/A	8
9			#N/A	#N/A	#N/A	#N/A	#N/A	9
10			#N/A	#N/A	#N/A	#N/A	#N/A	10
11			#N/A	#N/A	#N/A	#N/A	#N/A	11
12			#N/A	#N/A	#N/A	#N/A	#N/A	12
13			#N/A	#N/A	#N/A	#N/A	#N/A	13
14			#N/A	#N/A	#N/A	#N/A	#N/A	14
15			#N/A	#N/A	#N/A	#N/A	#N/A	15
16			#N/A	#N/A	#N/A	#N/A	#N/A	16
17			#N/A	#N/A	#N/A	#N/A	#N/A	17
18			#N/A	#N/A	#N/A	#N/A	#N/A	18
19			#N/A	#N/A	#N/A	#N/A	#N/A	19
20			#N/A	#N/A	#N/A	#N/A	#N/A	20
21			#N/A	#N/A	#N/A	#N/A	#N/A	21
22			#N/A	#N/A	#N/A	#N/A	#N/A	22
23			#N/A	#N/A	#N/A	#N/A	#N/A	23
24			#N/A	#N/A	#N/A	#N/A	#N/A	24
25			#N/A	#N/A	#N/A	#N/A	#N/A	25
26			#N/A	#N/A	#N/A	#N/A	#N/A	26
27			#N/A	#N/A	#N/A	#N/A	#N/A	27
28			#N/A	#N/A	#N/A	#N/A	#N/A	28
29			#N/A	#N/A	#N/A	#N/A	#N/A	29
30			#N/A	#N/A	#N/A	#N/A	#N/A	30

Facility Name & ID Number North Church Nursing And Rehab. # 0051094 Report Period Beginning: 01/01/11 Ending: 12/31/11

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Relative	Administrative	0.00%	See Attached	2.4	6.00%	Consult. Fees	\$ 4,000	17-3	1
2	David Berkowitz	Owner	Administrative	36.50%	See Attached	2.4	6.00%	Consult. Fees	7,000	17-3	2
3	Joel Meystel	Relative	Administrative	N/A	See Attached	1.2	6.00%	Alloc. Salary	1,383	17-7	3
4	Jay Meystel	Relative	Administrative	0.00%	See Attached	1.2	3.00%	Alloc. Salary	3,633	17-7	4
5	Fred Frankel	Owner	Administrative	1.00%	See Attached	2.4	6.00%	Alloc. Salary	8,546	17-7	5
6	Steve Turofsky	Owner	Administrative	1.00%	See Attached	2.4	6.00%	Alloc. Salary	6,685	17-7	6
7	Christina Inofre	Owner	Nursing	1.00%	See Attached	2.4	6.00%	Alloc. Salary	6,398	10-7	7
8											8
9	Where applicable, the amounts reported on this page have been adjusted from the actual costs to										9
10	reflect only amounts anticipated to be considered allowable by the Illinois Department of HFS.										10
11											11
12											12
13								TOTAL	\$ 37,645		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Church Nursing And Rehab.

# 0051094

Report Period Beginning:

01/01/11

Ending: 12/31/11

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Church Nursing And Rehab.

# 0051094

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V 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	686,836	17	\$ 15,204	\$ 41,245	\$ 913	1	
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	686,836	17	25,846	8,238	41,245	1,552	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	686,836	17	1,829	41,245	110	3	
4	17	ADMINISTRATIVE	AVAIL. BED DAYS	686,836	17	356,736	356,736	41,245	21,422	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	26,635	41,245	1,599	5	
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	6,564	41,245	394	6	
7	21	CLERICAL & GENERAL	AVAIL. BED DAYS	686,836	17	890,719	835,933	41,245	53,488	7
8	24	SEMINARS	AVAIL. BED DAYS	686,836	17	10,148	41,245	609	8	
9	25	AUTO AND TRAVEL	AVAIL. BED DAYS	686,836	17	29,510	41,245	1,772	9	
10	26	INSURANCE	AVAIL. BED DAYS	686,836	17	21,145	41,245	1,270	10	
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	686,836	17	236,117	41,245	14,179	11	
12	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	16,611	41,245	997	12	
13	32	INTEREST	AVAIL. BED DAYS	686,836	17	1,006	41,245	60	13	
14	33	REAL ESTATE TAX	AVAIL. BED DAYS	686,836	17	46,424	41,245	2,788	14	
15	34	RENT	AVAIL. BED DAYS	686,836	17	156,000	41,245	9,368	15	
16	35	AUTO RENTAL	AVAIL. BED DAYS	686,836	17	18,091	41,245	1,086	16	
17	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	686,836	17	6,400	41,245	384	17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,864,985	\$ 1,200,907	\$ 111,991	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Church Nursing And Rehab.

# 0051094

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY	AVAIL. BED DAYS	686,836	17	\$ 132,684	\$ 123,698	41,245	\$ 7,968	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	686,836	17	15,896		41,245	955	2
3	10	NURSING SALARY	AVAIL. BED DAYS	686,836	17	597,577	597,577	41,245	35,885	3
4	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	686,836	17	38,325		41,245	2,301	4
5	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	686,836	17	74,394		41,245	4,467	5
6	17	ADMINISTRATIVE	AVAIL. BED DAYS	686,836	17	195,987	195,987	41,245	11,769	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	51,975		41,245	3,121	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	849		41,245	51	8
9	21	CLERICAL & GENERAL	AVAIL. BED DAYS	686,836	17	107,160	91,547	41,245	6,435	9
10	24	SEMINARS	AVAIL. BED DAYS	686,836	17	3,858		41,245	232	10
11	25	AUTO AND TRAVEL	AVAIL. BED DAYS	686,836	17	5,508		41,245	331	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	686,836	17	30,309		41,245	1,820	12
13	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	673		41,245	40	13
14	35	AUTO RENTAL	AVAIL. BED DAYS	686,836	17	61,921		41,245	3,718	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,317,116	\$ 1,008,809		\$ 79,093	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Church Nursing And Rehab.

# 0051094

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V 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	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	\$ 5,168	\$ 20,440	\$ 310	1
2	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	624	20,440	37	2
3	21	OFFICE EXPENSE	AVAIL. BED DAYS	686,836	17	1,000	20,440	60	3
4	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	51,542	20,440	3,095	4
5	32	INTEREST EXPENSE	AVAIL. BED DAYS	686,836	17	55,103	20,440	3,309	5
6	33	REAL ESTATE TAXES	AVAIL. BED DAYS	686,836	17	29,058	20,440	1,745	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 142,495	\$	\$ 8,556	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Church Nursing And Rehab.

# 0051094

Report Period Beginning:

01/01/11

Ending: 12/31/11

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Church Nursing And Rehab.

# 0051094

Report Period Beginning:

01/01/11

Ending: 12/31/11

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Church Nursing And Rehab.

# 0051094

Report Period Beginning:

01/01/11

Ending: 12/31/11

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Church Nursing And Rehab.

# 0051094

Report Period Beginning:

01/01/11

Ending: 12/31/11

**VIII. ALLOCATION OF INDIRECT COSTS**

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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 North Church Nursing And Rehab.

# 0051094

Report Period Beginning:

01/01/11

Ending: 12/31/11

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Church Nursing And Rehab.

# 0051094

Report Period Beginning:

01/01/11

Ending: 12/31/11

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

North Church Nursing And Rehab.

# 0051094

Report Period Beginning:

01/01/11

Ending:

12/31/11

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Bank Financial		X	Mortgage			\$	\$ 1,744,774		\$ 110,154	1								
2											2								
3											3								
4											4								
5	See Supplemental Schedule										5								
<b>Working Capital</b>																			
6	Bank Financial		X	Line of Credit				588,851		11,696	6								
7	Assurance		X	Insurance Financing						1,316	7								
8	See Supplemental Schedule										8								
9	TOTAL Facility Related						\$	\$ 2,333,625		\$ 123,167	9								
<b>B. Non-Facility Related*</b>																			
10	Interest Income		X							(20)	10								
11	YAM Management Allocation	X								60	11								
12	8131 N. Monticello Allocation	X								3,309	12								
13	See Supplemental Schedule										13								
14	TOTAL Non-Facility Related						\$	\$		\$ 3,349	14								
15	TOTALS (line 9+line14)						\$	\$ 2,333,625		\$ 126,516	15								

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

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

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

Facility Name & ID Number North Church Nursing And Rehab. # 0051094 Report Period Beginning: 01/01/11 Ending: 12/31/11

**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		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>											7							
	<b>Working Capital</b>																		
8							\$	\$			\$	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	<b>TOTAL Working Capital</b>											14							
	<b>B. Non-Facility Related*</b>																		
15							\$	\$			\$	15							
16												16							
17												17							
18												18							
19												19							
20	<b>TOTAL Non-Facility Related</b>											20							

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

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

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2010 report.		\$	<b>33,222</b>		<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>34,967</b>		<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>1,745</b>		<b>3</b>
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>33,221</b>		<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>34,966</b>		<b>7</b>
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006	_____	<b>8</b>	<b>FOR BHF USE ONLY</b>	
	2007	_____	<b>9</b>		
	2008	_____	<b>10</b>	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2010 \$ <b>13</b>
	2009	_____	<b>11</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$ <b>14</b>
	2010	<b>33,222</b>	<b>12</b>	<b>15</b>	LESS REFUND FROM LINE 6 \$ <b>15</b>
<b>2011 Accrual = 2010 Tax (Rounded)</b>				<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$ <b>16</b>
<b>8131 N. Monticello Allocation = \$1,745</b>					

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**SEE ACCOUNTANTS' COMPILATION REPORT**



# 2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME North Church Nursing And Rehab. COUNTY Morgan

FACILITY IDPH LICENSE NUMBER 0051094

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

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

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

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

Facility Name & ID Number North Church Nursing And Rehab.

# 0051094

Report Period Beginning:

01/01/11

Ending:

12/31/11

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 24,500 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

N/A

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Allocated from 8131 N. Monticello</u>		<u>2010</u>	<u>\$ 5,345</u>	<u>1</u>
2	<u>Allocated from Centralia Property, LLC</u>		<u>2010</u>	<u>48,177</u>	<u>2</u>
3	<b>TOTALS</b>			<b>\$ 53,522</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Church Nursing And Rehab.

# 0051094

Report Period Beginning:

01/01/11

Ending:

12/31/11

**XI. OWNERSHIP COSTS (continued)**

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

	1	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	113		2010	1977	\$ 1,056,272	\$ 14,667	20	\$ 30,177	\$ 15,510	\$ 40,239	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68		62,107	3,293		2,193	(1,100)	3,236	68
69			22,088			(22,088)		69
70		\$ 1,118,379	\$ 40,048		\$ 32,370	\$ (7,678)	\$ 43,475	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,118,379	\$ 40,048		\$ 32,370	\$ (7,678)	\$ 43,475	1
2	Camera Security System	2011	8,382		20	1,397	1,397	1,397	2
3	Roof Replacement & Gutter Repair	2011	98,124		20	8,177	8,177	8,177	3
4	Resident Rms-Window Cornices, Blinds, Cubicle Curtains	2011	27,355		20	2,736	2,736	2,736	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)		\$ 1,252,240	\$ 40,048		\$ 44,680	\$ 4,631	\$ 55,785	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number North Church Nursing And Rehab.

# 0051094

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 1,252,240	\$ 40,048		\$ 44,680	\$ 4,631	\$ 55,785	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		\$ 1,252,240	\$ 40,048		\$ 44,680	\$ 4,631	\$ 55,785	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$ 1,252,240	\$ 40,048		\$ 44,680	\$ 4,631	\$ 55,785
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 1,252,240	\$ 40,048		\$ 44,680	\$ 4,631	\$ 55,785

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,252,240	\$ 40,048		\$ 44,680	\$ 4,631	\$ 55,785	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)	\$ 1,252,240	\$ 40,048		\$ 44,680	\$ 4,631	\$ 55,785	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Building Company 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									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.

Facility Name & ID Number North Church Nursing And Rehab.

# 0051094

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

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

1	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)	\$	\$		\$	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Related Party Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3	Allocated from 8131 N. Monticello	2010	41,527	1,235	39	1,065	(170)	1,553	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	Allocated from 8131 N. Monticello	2010	18,602	1,860	20	930	(930)	1,431	9
10	Allocated from YAM Management	2010	1,978	198	20	198		252	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1								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)		\$ 62,107	\$ 3,293		\$ 2,193	\$ (1,100)	\$ 3,236	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number North Church Nursing And Rehab.

# 0051094

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 177,308	\$ 137,487	\$ 17,800	\$ (119,687)	10	\$ 23,561	71
72	Current Year Purchases	16,443	7	1,293	1,286	10	1,293	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 193,751	\$ 137,494	\$ 19,093	\$ (118,401)		\$ 24,854	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		YAM MANAGEMENT, LLC	2009	\$ 1,615	\$ 179	\$ 179	\$	5	\$ 61	76
77										77
78										78
79										79
80	TOTALS			\$ 1,615	\$ 179	\$ 179	\$		\$ 61	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)	\$ 1,501,128	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 177,721	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 63,951	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (113,770)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 80,699	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	Arch., Electrical, Roof	\$ 68,195	92
93			93
94			94
95		\$ 68,195	95

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

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

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ 1,779 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2010 Ford E-350	\$ _____	\$ <u>16,574</u>	17
18	Allocated from YAM Management			<u>1,086</u>	18
19	Allocated from YAM Consulting			<u>3,718</u>	19
20					20
21	TOTAL		\$ _____	\$ <u>21,378</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. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

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

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

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

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

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 146,640	\$		\$ 146,640	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			22,339			22,339	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			106,137			106,137	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				68,656		68,656	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>See Supplemental</u>					15,680	2,875		18,555	13
14	TOTAL			\$		\$ 290,796	\$ 71,531		\$ 362,327	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 North Church Nursing And Rehab.

# 0051094

Report Period Beginning: 01/01/11

Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11

(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	\$ 1,000	\$ 1,737	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	862,652	862,652	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	61,367	61,367	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	289,686	533,169	8
9	Other(specify): <u>See Attached Schedule</u>	203,965	203,965	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,418,670	\$ 1,662,890	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		312,840	13
14	Buildings, at Historical Cost		510,132	14
15	Leasehold Improvements, at Historical Cost	135,460	197,329	15
16	Equipment, at Historical Cost	52,369	418,887	16
17	Accumulated Depreciation (book methods)	(25,396)	(205,608)	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>	902,435	902,435	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,064,868	\$ 2,136,015	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,483,538	\$ 3,798,905	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 365,316	\$ 365,316	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,006	5,006	28
29	Short-Term Notes Payable		1,744,774	29
30	Accrued Salaries Payable	82,618	82,618	30
31	Accrued Taxes Payable (excluding real estate taxes)	39,173	39,173	31
32	Accrued Real Estate Taxes(Sch.IX-B)	33,221	33,221	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	1,037,933	224,726	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,563,267	\$ 2,494,834	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	588,851	588,851	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Schedule</u>		394,531	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 588,851	\$ 983,382	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,152,118	\$ 3,478,216	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 331,420	\$ 320,689	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,483,538	\$ 3,798,905	48

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>7,490</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>7,490</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>340,597</b>	<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	<b>(16,667)</b>	<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>	\$ <b>323,930</b>	<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>	\$ <b>331,420</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number North Church Nursing And Rehab.

# 0051094

Report Period Beginning: 01/01/11

Ending: 12/31/11

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	\$ 2,868,901	1
2	Discounts and Allowances for all Levels	(101,917)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,766,984	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	767,353	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 767,353	8
<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	64,303	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,076	19
20	Radiology and X-Ray	90	20
21	Other Medical Services	1,291	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 68,760	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	20	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 20	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	3,116	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 3,116	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,606,233	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	533,120	31
32	Health Care	1,188,465	32
33	General Administration	738,794	33
<b>B. Capital Expense</b>			
34	Ownership	240,771	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	502,618	35
36	Provider Participation Fee	61,868	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,265,636	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	340,597	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 340,597	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number North Church Nursing And Rehab.

# 0051094

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	1,993	2,086	\$ 65,621	\$ 31.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,522	5,815	151,596	26.07	3
4	Licensed Practical Nurses	14,382	15,149	309,652	20.44	4
5	CNAs & Orderlies	36,342	38,166	437,768	11.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,745	1,820	27,538	15.13	8
9	Activity Director	1,766	1,971	21,720	11.02	9
10	Activity Assistants	1,236	1,256	10,699	8.52	10
11	Social Service Workers	752	785	11,874	15.13	11
12	Dietician					12
13	Food Service Supervisor	1,760	1,800	22,500	12.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,401	10,000	95,799	9.58	15
16	Dishwashers					16
17	Maintenance Workers	6,349	6,625	65,915	9.95	17
18	Housekeepers	8,323	8,700	82,915	9.53	18
19	Laundry	2,648	2,786	26,910	9.66	19
20	Administrator	1,960	2,072	75,977	36.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,875	4,250	55,545	13.07	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,747	2,079	46,853	22.54	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	99,800	105,359	\$ 1,508,882 *	\$ 14.32	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	105	\$ 5,859	01-03	35
36	Medical Director	Monthly	15,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	443	33,279	10-03	38
39	Pharmacist Consultant	40	2,115	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	35	1,769	11-03	44
45	Social Service Consultant	70	3,551	12-03	45
46	Other(specify)				46
47	<u>Psychiatric M.D.</u>	Monthly	892	12-03	47
48					48
49	TOTAL (lines 35 - 48)	693	\$ 62,465		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-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
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16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number North Church Nursing And Rehab.

# 0051094

Report Period Beginning:

01/01/11

Ending:

12/31/11

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. ICLTC \$10,985
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,017 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 61,868  
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. \$ 1,729 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14  
d. Have vehicle usage logs been maintained? No  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ No**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**