

Facility Name & ID Number Concord Nursing & Rehab Center

0050500 Report Period Beginning: 01/01/12 Ending: 12/31/12

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>134</u>	Skilled (SNF)	<u>134</u>	<u>49,044</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>134</u>	TOTALS	<u>134</u>	<u>49,044</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>35,071</u>	<u>2,261</u>	<u>7,826</u>	<u>45,158</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>35,071</u>	<u>2,261</u>	<u>7,826</u>	<u>45,158</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.08%

D. How many bed-hold days during this year were paid by the Department? 567 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 1962

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 134 and days of care provided 4,416

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Concord Nursing & Rehab Center # 0050500 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	218,944	19,294	25,200	263,438		263,438	9,178	272,616		1
2	Food Purchase		221,616		221,616		221,616	(111)	221,505		2
3	Housekeeping	130,622	22,299		152,921		152,921		152,921		3
4	Laundry	105,856	16,236		122,092		122,092		122,092		4
5	Heat and Other Utilities			128,221	128,221		128,221	(8,331)	119,890		5
6	Maintenance	68,253	31,954	92,066	192,273		192,273	33,546	225,819		6
7	Other (specify):*							1,696	1,696		7
8	TOTAL General Services	523,675	311,399	245,487	1,080,561		1,080,561	35,978	1,116,539		8
	B. Health Care and Programs										
9	Medical Director			20,000	20,000		20,000		20,000		9
10	Nursing and Medical Records	2,152,714	161,067	46,502	2,360,283		2,360,283	(50,026)	2,310,257		10
10a	Therapy	47,685			47,685		47,685		47,685		10a
11	Activities	84,786	3,928	1,110	89,824		89,824		89,824		11
12	Social Services	68,311		2,565	70,876		70,876		70,876		12
13	CNA Training										13
14	Program Transportation			1,211	1,211		1,211	1,914	3,125		14
15	Other (specify):*							5,790	5,790		15
16	TOTAL Health Care and Programs	2,353,496	164,995	71,388	2,589,879		2,589,879	(42,322)	2,547,557		16
	C. General Administration										
17	Administrative	113,579		90,205	203,784		203,784	10,830	214,614		17
18	Directors Fees										18
19	Professional Services			267,217	267,217	(16,112)	251,105	(169,896)	81,209		19
20	Dues, Fees, Subscriptions & Promotions			71,760	71,760		71,760	(17,159)	54,601		20
21	Clerical & General Office Expenses	169,571		149,310	318,881		318,881	(30,636)	288,245		21
22	Employee Benefits & Payroll Taxes			498,851	498,851		498,851		498,851		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,466	3,466		3,466	1,495	4,961		24
25	Other Admin. Staff Transportation			4,977	4,977		4,977	1,641	6,618		25
26	Insurance-Prop.Liab.Malpractice			118,685	118,685		118,685	1,645	120,330		26
27	Other (specify):*							22,787	22,787		27
28	TOTAL General Administration	283,150		1,204,471	1,487,621	(16,112)	1,471,509	(179,293)	1,292,216		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,160,321	476,394	1,521,346	5,158,061	(16,112)	5,141,949	(185,637)	4,956,312		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			94,769	94,769		94,769	(38,998)	55,771			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			47,091	47,091		47,091	5,366	52,457			32
33	Real Estate Taxes			307,616	307,616	16,112	323,728	4,069	327,797			33
34	Rent-Facility & Grounds			714,825	714,825		714,825	(12,000)	702,825			34
35	Rent-Equipment & Vehicles			304	304		304	4,749	5,053			35
36	Other (specify):*											36
37	TOTAL Ownership			1,164,605	1,164,605	16,112	1,180,717	(36,814)	1,143,902			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		196,700	504,573	701,273		701,273		701,273			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			504,682	504,682		504,682		504,682			42
43	Other (specify):*	7,898		412,600	420,498		420,498	(420,498)				43
44	TOTAL Special Cost Centers	7,898	196,700	1,421,855	1,626,453		1,626,453	(420,498)	1,205,955			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,168,219	673,094	4,107,806	7,949,119		7,949,119	(642,950)	7,306,169			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(9,277)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(44,012)	30		9
10	Interest and Other Investment Income	(2)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(111)	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	(137)	21		18
19	Entertainment	(12,006)	21		19
20	Contributions	(18,100)	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	(56,313)	21		24
25	Fund Raising, Advertising and Promotional				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	(457,915)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (597,874)		\$	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)	(45,076)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (45,076)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (642,950)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Concord Nursing & Rehab Center

ID# 0050500
 Report Period Beginning: 01/01/12
 Ending: 12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Veterans Expense	\$ (30,610)	10	1
2	Marketing Expense	(12,666)	43	2
3	Bank Charges	(9,414)	21	3
4	Theft	(2,130)	21	4
5	Other Unclassified Income	(12,205)	21	5
6	Vending Commissions	(900)	21	6
7	Additional R&M	30,220	06	7
8	Non-allowable Legal	(7,180)	19	8
9	Non-allowable Expense	(401,832)	43	9
10	State Replacement Tax	(11,198)	21	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
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(457,915)		49

Concord Nursing & Rehab Center

ID# 0050500
 Report Period Beginning: 01/01/12
 Ending: 12/31/12

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Concord Nursing & Rehab Center# 0050500

Report Period Beginning:

01/01/12

Ending:

12/31/12

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				9,178								9,178	1
2	Food Purchase	(111)											(111)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(9,277)		946									(8,331)	5
6	Maintenance	30,220		1,820	1,506								33,546	6
7	Other (specify):*			139	1,557								1,696	7
8	TOTAL General Services	20,832		2,905	12,241								35,978	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(30,610)			(19,416)								(50,026)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation				1,914								1,914	14
15	Other (specify):*				5,790								5,790	15
16	TOTAL Health Care and Programs	(30,610)			(11,712)								(42,322)	16
	C. General Administration													
17	Administrative			25,429	(14,599)								10,830	17
18	Directors Fees													18
19	Professional Services	(7,180)		(151,284)	(11,582)	150							(169,896)	19
20	Fees, Subscriptions & Promotions	(18,100)		809	87	45							(17,159)	20
21	Clerical & General Office Expenses	(104,303)		66,396	7,271								(30,636)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			332	1,163								1,495	24
25	Other Admin. Staff Transportation			1,108	533								1,641	25
26	Insurance-Prop.Liab.Malpractice			1,645									1,645	26
27	Other (specify):*			17,576	5,211								22,787	27
28	TOTAL General Administration	(129,583)		(37,989)	(11,916)	195							(179,293)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(139,361)		(35,084)	(11,387)	195							(185,637)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Concord Nursing & Rehab Center# 0050500

Report Period Beginning:

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

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(44,012)		1,390		3,624							(38,998)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2)		1,772		3,596							5,366	32
33	Real Estate Taxes					4,069							4,069	33
34	Rent-Facility & Grounds			2,626		(14,626)							(12,000)	34
35	Rent-Equipment & Vehicles			1,922	2,827								4,749	35
36	Other (specify):*													36
37	TOTAL Ownership	(44,014)		7,710	2,827	(3,337)							(36,814)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(414,498)			(6,000)								(420,498)	43
44	TOTAL Special Cost Centers	(414,498)			(6,000)								(420,498)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(597,874)		(27,374)	(14,560)	(3,142)							(642,950)	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 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		\$			\$	\$	1
2	V							2
3	V							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		\$			\$	\$ *	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%	\$ 946	\$	946	15
16	V	6 REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	1,820		1,820	16
17	V	7 EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	139		139	17
18	V	17 ADMINISTRATIVE		YAM MANAGEMENT, LLC	100.00%	25,429		25,429	18
19	V	19 PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	1,565		1,565	19
20	V	20 FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	809		809	20
21	V	21 CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	66,396		66,396	21
22	V	24 SEMINARS		YAM MANAGEMENT, LLC	100.00%	332		332	22
23	V	25 AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	1,108		1,108	23
24	V	26 INSURANCE		YAM MANAGEMENT, LLC	100.00%	1,645		1,645	24
25	V	27 EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	17,576		17,576	25
26	V	30 DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	1,390		1,390	26
27	V	32 INTEREST		YAM MANAGEMENT, LLC	100.00%	1,772		1,772	27
28	V	33 REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%				28
29	V	34 RENT		YAM MANAGEMENT, LLC	100.00%	14,626		14,626	29
30	V	35 AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	1,668		1,668	30
31	V	EQUIPMENT RENTAL		YAM MANAGEMENT, LLC	100.00%	254		254	31
32	V			YAM MANAGEMENT, LLC	100.00%				32
33	V								33
34	V								34
35	V	19 BOOKKEEPING FEES	112,921	YAM MANAGEMENT, LLC	100.00%			(112,921)	35
36	V	19 ACCOUNTING	36,000	YAM MANAGEMENT, LLC	100.00%			(36,000)	36
37	V	34 RENT	12,000	YAM MANAGEMENT, LLC	100.00%			(12,000)	37
38	V	19 PROFESSIONAL	3,928	YAM MANAGEMENT, LLC	100.00%			(3,928)	38
39	Total		\$ 164,849			\$ 137,475	\$ *	(27,374)	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	1	DIETARY		100.00%	\$ 9,178	\$	9,178	15
16	V	7	EMP. BEN. GEN. SERV.		100.00%	1,557		1,557	16
17	V	10	NURSING SALARY		100.00%	43,734		43,734	17
18	V	14	PROGRAM TRANSPORTATION		100.00%	1,914		1,914	18
19	V	15	EMP. BEN. HEALTHCARE		100.00%	5,790		5,790	19
20	V	17	ADMINISTRATIVE		100.00%	23,606		23,606	20
21	V	19	PROFESSIONAL FEES		100.00%	394		394	21
22	V	20	FEES, SUBSCRIPTIONS		100.00%	87		87	22
23	V	21	CLERICAL & GENERAL		100.00%	7,271		7,271	23
24	V	24	SEMINARS		100.00%	1,163		1,163	24
25	V	25	AUTO AND TRAVEL		100.00%	533		533	25
26	V	27	EMP. BEN.-GEN. ADMIN.		100.00%	5,211		5,211	26
27	V	30	DEPRECIATION		100.00%				27
28	V	35	AUTO RENTAL		100.00%	2,827		2,827	28
29	V	6	REPAIRS AND MAINTENANCE SALARY		100.00%	2,146		2,146	29
30	V								30
31	V								31
32	V								32
33	V	10	DIETICIAN CONSULTING		100.00%			(23,100)	33
34	V	10	NURSE CONSULTING		100.00%			(40,050)	34
35	V	17	DIR. OF OPERATIONS CONSULT		100.00%			(38,205)	35
36	V	19	DATA PROCESSING FEES		100.00%			(11,976)	36
37	V	43	MARKETING		100.00%			(6,000)	37
38	V	6	PAINTER		100.00%			(640)	38
39	Total		\$ 119,971			\$ 105,411	\$ *	(14,560)	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	19 PROFESSIONAL FEES	\$	8131 N. MONTICELLO, LLC	100.00%	\$ 150	\$	150	15
16	V	20 DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		45		45	16
17	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC					17
18	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC		3,624		3,624	18
19	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC		3,596		3,596	19
20	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		4,069		4,069	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34 RENT	14,626	8131 N. MONTICELLO, LLC				(14,626)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 14,626			\$ 11,484	\$ *	(3,142)	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	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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	Total		\$			\$	\$ *	39

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

Facility Name & ID Number

Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	1219 Limited Partnership	2.000%	BERKSHIRE NURSING & REHAB CENTER,LLC	FOREST PARK	YAM MANAGEMENT	SKOKIE	MANAGEMENT CO.	1
2	257 Limited Partnership	4.000%	DOLTON NURSING & REHAB,LLC	DOLTON	YAM CONSULTING	SKOKIE	CONSULTING CO.	2
3	42170 Limited Partnership	2.000%	EVANSTON NURSING & REHAB CENTER, LLC	EVANSTON	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDIN	3
4	Concord SNF Equity Partners, LLC	45.000%	EXCEPTIONAL CARE, LLC	BURBANK				4
5	David Berkowitz	23.500%	FAIRVIEW CARE CENTER OF JOLIET,LLC	JOLIET				5
6	Jay Meystel Trust	12.500%	HIGHLAND PARK NURSING AND REHAB CENTER, LLC	HIGHWOOD				6
7	Declaration of Trust of Yosef	11.000%	INTERNATIONAL NURSING & REHAB CENTER,LLC	CHICAGO				7
8			LITCHFIELD CARE CENTER,LLC	LITCHFIELD				8
9			NORTH CHURCH NURSING & REHAB,LLC	JACKSONVILLE				9
10			PLAZA NURSING AND REHAB CENTER,LLC	MIDLOTHIAN				10
11			PLUM GROVE NURSING AND REHAB,LLC	PALATINE				11
12			RIVIERA CARE CENTER,LLC	CHICAGO HEIGHTS				12
13			SPRINGFIELD CARE CENTER,LLC	SPRINGFIELD				13
14			ARBOURS	MICHIGAN CITY, IN				14
15			COPPERAS HOLLOW	CALDWELL, TX				15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/12

Ending:

12/31/12

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center # 0050500 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	David Berkowitz	Owner	Administrative	23.50	See Attached	2.8	7.00%	Mgmt Fees	\$ 31,000	17-3	1
2	Yosef Meystel	Relative	Administrative		See Attached	2.8	7.00%	Mgmt Fees	21,000	17-3	2
3	Joel Meystel	Relative	Administrative		See Attached	1.4	7.00%	Alloc. Salary	1,610	17-7	3
4	Jay Meystel	Relative	Administrative		See Attached	1.4	3.50%	Alloc. Salary	4,283	17-7	4
5	Cynthia Meystel	Relative	Clerical		See Attached	0.2	6.06%	Alloc. Salary	322	21-7	5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 58,215		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/12

Ending: 12/31/12

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	697,482	17	\$ 13,451	\$ 49,044	\$ 946	1	
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	697,482	17	25,882	8,567	49,044	1,820	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	697,482	17	1,974		49,044	139	3
4	17	ADMINISTRATIVE	AVAIL. BED DAYS	697,482	17	361,644	361,644	49,044	25,429	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	697,482	17	22,257		49,044	1,565	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	697,482	17	11,509		49,044	809	6
7	21	CLERICAL & GENERAL	AVAIL. BED DAYS	697,482	17	944,249	887,220	49,044	66,396	7
8	24	SEMINARS	AVAIL. BED DAYS	697,482	17	4,715		49,044	332	8
9	25	AUTO AND TRAVEL	AVAIL. BED DAYS	697,482	17	15,759		49,044	1,108	9
10	26	INSURANCE	AVAIL. BED DAYS	697,482	17	23,390		49,044	1,645	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	697,482	17	249,963		49,044	17,576	11
12	30	DEPRECIATION	AVAIL. BED DAYS	697,482	17	19,767		49,044	1,390	12
13	32	INTEREST	AVAIL. BED DAYS	697,482	17	25,195		49,044	1,772	13
14	33	REAL ESTATE TAX	AVAIL. BED DAYS	697,482	17	-		49,044		14
15	34	RENT	AVAIL. BED DAYS	697,482	17	208,000		49,044	14,626	15
16	35	AUTO RENTAL	AVAIL. BED DAYS	697,482	17	23,725		49,044	1,668	16
17	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	697,482	17	3,615		49,044	254	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,955,095	\$ 1,257,431	\$	137,475	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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	DIETARY	AVAIL. BED DAYS	697,482	17	\$ 130,530	\$ 122,357	49,044	\$ 9,178	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	697,482	17	22,148		49,044	1,557	2
3	10	NURSING SALARY	AVAIL. BED DAYS	697,482	17	621,969	621,969	49,044	43,734	3
4	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	697,482	17	27,214		49,044	1,914	4
5	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	697,482	17	82,340		49,044	5,790	5
6	17	ADMINISTRATIVE	AVAIL. BED DAYS	697,482	17	335,714	335,714	49,044	23,606	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	697,482	17	5,608		49,044	394	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	697,482	17	1,231		49,044	87	8
9	21	CLERICAL & GENERAL	AVAIL. BED DAYS	697,482	17	103,402	93,384	49,044	7,271	9
10	24	SEMINARS	AVAIL. BED DAYS	697,482	17	16,540		49,044	1,163	10
11	25	AUTO AND TRAVEL	AVAIL. BED DAYS	697,482	17	7,585		49,044	533	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	697,482	17	74,111		49,044	5,211	12
13	30	DEPRECIATION	AVAIL. BED DAYS	697,482	17	-		49,044		13
14	35	AUTO RENTAL	AVAIL. BED DAYS	697,482	17	40,201		49,044	2,827	14
15	6	REPAIRS AND MAINTENANCE	AVAIL. BED DAYS	697,482	17	30,518		49,044	2,146	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,499,111	\$ 1,173,424		\$ 105,411	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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	19	PROFESSIONAL FEES	AVAIL. BED DAYS	697,482	17	\$ 2,136	\$ 49,044	\$ 150	1
2	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	697,482	17	645	49,044	45	2
3	21	OFFICE EXPENSE	AVAIL. BED DAYS	697,482	17	-	49,044		3
4	30	DEPRECIATION	AVAIL. BED DAYS	697,482	17	51,541	49,044	3,624	4
5	32	INTEREST EXPENSE	AVAIL. BED DAYS	697,482	17	51,147	49,044	3,596	5
6	33	REAL ESTATE TAXES	AVAIL. BED DAYS	697,482	17	57,872	49,044	4,069	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					\$ 163,341	\$	\$ 11,484	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/12

Ending:

12/31/12

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5	See Supplemental Schedule									5										
Working Capital																				
6	Private Bank		X	Line of Credit				703,758		44,900	6									
7	Insurance Financing		X							2,191	7									
8	See Supplemental Schedule										8									
9	TOTAL Facility Related							\$ 703,758		\$ 47,091	9									
B. Non-Facility Related*																				
10	Interest Income		X							(2)	10									
11	Allocated from YAM Management		X							1,772	11									
12	Allocated from 8131 N Monticello		X							3,596	12									
13	See Supplemental Schedule										13									
14	TOTAL Non-Facility Related							\$		\$ 5,366	14									
15	TOTALS (line 9+line14)							\$ 703,758		\$ 52,457	15									

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

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

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

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.		\$	219,616		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	267,686		2
3. Under or (over) accrual (line 2 minus line 1).		\$	48,070		3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	263,616		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	16,112		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	327,798		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2007	156,982			8
	2008	290,460			9
	2009	220,150			10
	2010	219,616			11
	2011	263,617			12
2012 Accrual = 2011 Tax Bill					
Allocated from 8131 N. Monticello = \$4,069					
FOR BHF USE ONLY					
	13	FROM R. E. TAX STATEMENT FOR 2011	\$		13
	14	PLUS APPEAL COST FROM LINE 5	\$		14
	15	LESS REFUND FROM LINE 6	\$		15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Concord Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050500

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 2011 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 2011.

	(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.	<u>24-05-302-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>263,616.90</u>	\$ <u>263,616.90</u>
2.	<u>10-23-325-045-0000</u>	<u>Home Office Allocation</u>	\$ <u>66,065.10</u>	\$ <u>4,069.33</u>
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u><u>329,682.00</u></u>	\$ <u><u>267,686.23</u></u>

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? X YES _____ NO

If YES, attach an explanation and 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 original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/12

Ending:

12/31/12

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,133 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Allocated from 8131 N. Monticello</u>			\$ <u>6,258</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ <u>6,258</u>	<u>3</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/12

Ending:

12/31/12

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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

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		74,084	4,398		2,615	(1,783)	6,402	68
69			94,769			(94,769)		69
70		\$ 74,084	\$ 99,167		\$ 2,615	\$ (96,552)	\$ 6,402	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 74,084	\$ 99,167		\$ 2,615	\$ (96,552)	\$ 6,402	1
2	Cable/Cameras/Labor	2009	11,266		20	563	563	2,018	2
3	Wire Building	2009	9,950		20	498	498	1,824	3
4	Flooring	2009	59,050		20	2,953	2,953	10,826	4
5	Nurse Station	2009	18,000		20	900	900	3,225	5
6	Boiler- Gas Valve	2010	2,899		20	290	290	870	6
7	Ramp Rails	2010	8,750		20	875	875	2,333	7
8	Rooftop Hvac	2010	7,900		20	790	790	2,041	8
9	Ceiling, Lighting, Wallcovering - Corridors & Nurses Station	2010	117,992		20	15,094	15,094	38,993	9
10	Missing Shingles	2010	2,950		20	295	295	688	10
11	Ejector Pump	2010	4,729		20	946	946	2,522	11
12	Hardwood Floor	2011	3,900		20	195	195	341	12
13	Plumbing	2011	5,200		20	260	260	390	13
14	Corridor Signage	2011	6,193		20	310	310	413	14
15	Boiler	2011	24,900		20	1,245	1,245	1,660	15
16	Hardwood Floor	2011	3,300		20	165	165	220	16
17	Tuck Pointing	2011	4,700		20	235	235	313	17
18	Vestibule - New Flooring, Wallcovering & Lighting	2011	7,144		20	357	357	446	18
19	Lobby - New Lighting	2011	3,133		20	157	157	196	19
20	Dining Room - New Wallcovering, Lighting, Replace Ceiling Tile	2011	37,703		20	1,885	1,885	2,199	20
21	Therapy Room - New Wallcovering, Lighting & Custom Built In C	2011	37,421		20	1,871	1,871	2,339	21
22	Lobby - Repair Wall, New Wallcovering, Paint Ceiling	2011	17,401		20	870	870	1,160	22
23	Parlor Area - New Wallcovering	2011	3,467		20	173	173	231	23
24	Dining Room - Install New Oak Plywood Over Beams	2011	14,186		20	709	709	946	24
25	Electric Work	2012	3,325		20	305	305	305	25
26	Fireplace Granite Surround/ Replace Studs And Drywall	2012	3,475		20	319	319	319	26
27	Window Panels	2012	44,429		20	3,332	3,332	3,332	27
28	Hydraulic Placecard	2012	2,500		20	146	146	146	28
29	Security System And Camera	2012	7,489		20	446	446	446	29
30	Asphalt & Restrip Parking Lot	2012	32,599		20	906	906	906	30
31	Wanderer System	2012	2,675		20	357	357	357	31
32	8000 Btu115 V Wall	2012	4,111		20	480	480	480	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 586,822	\$ 99,167		\$ 40,539	\$ (58,628)	\$ 88,886	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		\$ 586,822	\$ 99,167		\$ 40,539	\$ (58,628)	\$ 88,886	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)	\$ 586,822	\$ 99,167		\$ 40,539	\$ (58,628)	\$ 88,886	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		\$ 586,822	\$ 99,167		\$ 40,539	\$ (58,628)	\$ 88,886	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)	\$ 586,822	\$ 99,167		\$ 40,539	\$ (58,628)	\$ 88,886	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		\$ 586,822	\$ 99,167		\$ 40,539	\$ (58,628)	\$ 88,886	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)	\$ 586,822	\$ 99,167		\$ 40,539	\$ (58,628)	\$ 88,886	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
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 (12F & 12G lines 1 thru 33)	\$	\$		\$	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 8131 N. Monticello	2010	48,625	1,446	39	1,247	(199)	3,065	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from 8131 N. Monticello	2010	21,781	2,178	20	1,089	(1,089)	2,764	9
10	Allocated from YAM Management	2010	2,316	59	20	232	173	526	10
11	Allocated from YAM Management	2012	1,362	715	20	47	(668)	47	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)		\$ 74,084	\$ 4,398		\$ 2,615	\$ (1,783)	\$ 6,402	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	\$ 94,197	\$ 17	\$ 11,770	\$ 11,753	10	\$ 30,566	71
72	Current Year Purchases	19,758	573	2,840	2,267	10	2,840	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 113,954	\$ 590	\$ 14,610	\$ 14,020		\$ 33,407	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		Allocated from YAM Manager	2011	\$ 2,391	\$ 26	\$ 621	\$ 595	5	\$ 692	76
77										77
78										78
79										79
80	TOTALS			\$ 2,391	\$ 26	\$ 621	\$ 595		\$ 692	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)	\$ 709,425	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 99,783	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 55,771	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (44,012)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 122,985	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	Roofing & Econocare	\$ 105,145	92
93			93
94			94
95		\$ 105,145	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Concord Healthcare Properties

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:				\$ <u>701,791</u>			3
4	Additions							4
5	Public Storage				<u>1,034</u>			5
6								6
7	TOTAL				\$ <u>702,825</u>			7

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

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

9. Option to Buy: YES NO Terms: Option to purchase after 3/1/14 *

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: \$ 558 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from YAM Management		\$ _____	\$ <u>1,668</u>	17
18	Allocated from YAM Consulting			<u>2,827</u>	18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>4,495</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending 2/18/19

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 12/31/2013 \$ 724,128

13. 12/31/2014 \$ 748,402

14. 12/31/2015 \$ 772,678

* 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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6	7	8		
			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	\$		\$	178,320	\$			\$	178,320	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				99,532					99,532	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	39 - 03	hrs				201,535					201,535	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						191,482			191,482	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>						25,186		5,218			30,404	13	
14	TOTAL			\$		\$	504,573	\$	196,700	\$		701,273	14	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center# 0050500Report Period Beginning: 01/01/12Ending: 12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 244,220	\$	1
2	Cash-Patient Deposits	62,720		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,258,303		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	80,360		6
7	Other Prepaid Expenses	1,844		7
8	Accounts Receivable (owners or related parties)	625,000		8
9	Other(specify): <u>See Attached Schedule</u>	633,338		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,905,785	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	576,270		15
16	Equipment, at Historical Cost	156,002		16
17	Accumulated Depreciation (book methods)	(201,253)		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>	105,145		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 636,164	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,541,949	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 525,646	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	77,265		28
29	Short-Term Notes Payable	703,758		29
30	Accrued Salaries Payable	226,831		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,965		31
32	Accrued Real Estate Taxes(Sch.IX-B)	263,616		32
33	Accrued Interest Payable	1,922		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	11,198		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,833,201	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,833,201	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,708,748	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,541,949	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,359,326	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,359,326	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,353,922	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,004,500)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,349,422	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,708,748	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning: 01/01/12

Ending:

12/31/12

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**

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,780,684	1
2	Discounts and Allowances for all Levels	(1,450,923)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,329,761	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,806,268	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,806,268	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	128,009	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,183	19
20	Radiology and X-Ray	2,914	20
21	Other Medical Services	7,799	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 153,905	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	13,105	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 13,105	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,303,041	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,080,561	31
32	Health Care	2,589,879	32
33	General Administration	1,487,621	33
B. Capital Expense			
34	Ownership	1,164,605	34
C. Ancillary Expense			
35	Special Cost Centers	1,121,771	35
36	Provider Participation Fee	504,682	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,949,119	40
41	Income before Income Taxes (line 30 minus line 40)**	2,353,922	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,353,922	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 6,809,250	44
45	Private Pay - Net Inpatient Revenue	439,536	45
46	Medicare - Net Inpatient Revenue	468,812	46
47	Other-(specify) <u>Insurance</u>	414,748	47
48	Other-(specify) <u>Veteran</u>	197,415	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,329,761	49

* 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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Concord Nursing & Rehab Center**

0050500

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	1,940	2,091	\$ 85,717	\$ 40.99	1
2	Assistant Director of Nursing	1,730	1,925	69,292	36.00	2
3	Registered Nurses	9,339	9,822	305,944	31.15	3
4	Licensed Practical Nurses	31,632	33,785	860,506	25.47	4
5	CNAs & Orderlies	69,691	75,159	831,255	11.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,131	4,372	47,685	10.91	8
9	Activity Director	2,100	2,278	29,688	13.03	9
10	Activity Assistants	6,204	6,414	55,098	8.59	10
11	Social Service Workers	3,775	4,113	68,311	16.61	11
12	Dietician					12
13	Food Service Supervisor	1,686	1,833	36,046	19.67	13
14	Head Cook	2,680	3,031	31,948	10.54	14
15	Cook Helpers/Assistants	14,229	15,530	150,950	9.72	15
16	Dishwashers					16
17	Maintenance Workers	3,980	4,364	68,253	15.64	17
18	Housekeepers	12,295	13,315	130,622	9.81	18
19	Laundry	8,512	9,384	105,856	11.28	19
20	Administrator	2,355	2,701	112,136	41.52	20
21	Assistant Administrator	85	85	1,443	16.98	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,730	12,052	169,571	14.07	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					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	608	657	7,898	12.02	33
34	TOTAL (lines 1 - 33)	187,702	202,911	\$ 3,168,219 *	\$ 15.61	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	420	\$ 25,200	01-03	35
36	Medical Director	Monthly	20,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	801	40,050	10-03	38
39	Pharmacist Consultant	Monthly	6,452	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	37	1,110	11-03	44
45	Social Service Consultant	52	2,565	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,310	\$ 95,377		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													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center# 0050500

Report Period Beginning:

01/01/12

Ending:

12/31/12**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$10,886
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 25,540 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. _____
- (9) Are you presently operating under a sublease agreement? X YES _____ NO _____
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 504,682
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. \$ 1,011 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100 % line 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT