

Facility Name & ID Number Plaza Nursing & Rehab Center

0049858 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	48	Skilled (SNF)	48	17,520	1
2		Skilled Pediatric (SNF/PED)			2
3	43	Intermediate (ICF)	43	15,695	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	91	TOTALS	91	33,215	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	329	11	2,061	2,401	8
9	SNF/PED					9
10	ICF	28,120	132	158	28,410	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,449	143	2,219	30,811	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.76%

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 01/01/2008

J. Was the facility purchased or leased after January 1, 1978?
YES Date 01/01/2008 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 48 and days of care provided 2,061

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: 12/31/2013 Fiscal Year: 12/31/2013

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Plaza Nursing & Rehab Center

0049858

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	169,166	12,352	13,013	194,531		194,531	(6,195)	188,336		1
2	Food Purchase		138,396		138,396		138,396	(6)	138,390		2
3	Housekeeping	122,335	13,625		135,960		135,960		135,960		3
4	Laundry		11,924		11,924		11,924		11,924		4
5	Heat and Other Utilities			72,968	72,968		72,968	(5,319)	67,649		5
6	Maintenance	68,423	29,831	54,115	152,369		152,369	(1,510)	150,859		6
7	Other (specify):*							1,225	1,225		7
8	TOTAL General Services	359,924	206,128	140,096	706,148		706,148	(11,805)	694,343		8
	B. Health Care and Programs										
9	Medical Director			18,244	18,244		18,244		18,244		9
10	Nursing and Medical Records	1,175,487	46,475	78,609	1,300,571		1,300,571	(35,762)	1,264,809		10
10a	Therapy	57,541	2,800		60,341		60,341		60,341		10a
11	Activities	89,308	5,598	2,135	97,041		97,041		97,041		11
12	Social Services	73,030		6,352	79,382		79,382		79,382		12
13	CNA Training										13
14	Program Transportation			9,742	9,742		9,742	1,619	11,361		14
15	Other (specify):*							3,658	3,658		15
16	TOTAL Health Care and Programs	1,395,366	54,873	115,082	1,565,321		1,565,321	(30,485)	1,534,836		16
	C. General Administration										
17	Administrative	92,962		54,375	147,337		147,337	6,101	153,438		17
18	Directors Fees										18
19	Professional Services			265,767	265,767	(10,440)	255,327	(182,497)	72,830		19
20	Dues, Fees, Subscriptions & Promotions			29,919	29,919		29,919	(14,073)	15,846		20
21	Clerical & General Office Expenses	67,203		189,391	256,594		256,594	(91,081)	165,513		21
22	Employee Benefits & Payroll Taxes			317,190	317,190		317,190		317,190		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,411	1,411		1,411	544	1,955		24
25	Other Admin. Staff Transportation			2,740	2,740		2,740	3,049	5,789		25
26	Insurance-Prop.Liab.Malpractice			118,743	118,743		118,743	1,014	119,757		26
27	Other (specify):*							17,496	17,496		27
28	TOTAL General Administration	160,165		979,536	1,139,701	(10,440)	1,129,261	(259,447)	869,814		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,915,455	261,001	1,234,714	3,411,170	(10,440)	3,400,730	(301,737)	3,098,993		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Plaza Nursing & Rehab Center

#0049858

Report Period Beginning:

01/01/13

Ending:

12/31/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			67,004	67,004		67,004	(22,359)	44,645			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			37,066	37,066		37,066	2,078	39,144			32
33	Real Estate Taxes			146,282	146,282	10,440	156,722	2,529	159,251			33
34	Rent-Facility & Grounds			455,392	455,392		455,392	(12,000)	443,392			34
35	Rent-Equipment & Vehicles			1,790	1,790		1,790	2,627	4,417			35
36	Other (specify):*			12,987	12,987		12,987	(12,987)	0			36
37	TOTAL Ownership			720,521	720,521	10,440	730,961	(40,112)	690,849			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		110,811	226,704	337,515		337,515	(25,720)	311,795			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			182,336	182,336		182,336		182,336			42
43	Other (specify):*			198,785	198,785		198,785	(198,785)				43
44	TOTAL Special Cost Centers		110,811	607,825	718,636		718,636	(224,505)	494,131			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,915,455	371,812	2,563,060	4,850,327		4,850,327	(566,354)	4,283,973			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 Plaza Nursing & Rehab Center

0049858

Report Period Beginning: 01/01/13

Ending: 12/31/13

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	(5,959)	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	(25,527)	30		9
10	Interest and Other Investment Income	(772)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6)	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	(29,570)	21		18
19	Entertainment	(5,676)	21		19
20	Contributions	(12,750)	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	(112,268)	21		24
25	Fund Raising, Advertising and Promotional	(2,392)	43		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	(249,878)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (444,798)		\$	30

BHF USE ONLY					
48		49	50	51	52

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

		1	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)	(121,556)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (121,556)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (566,354)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Plaza Nursing & Rehab Center

ID# 0049858

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Non Allowable Professional Fees	\$ (51,000)	19	1
2	Jury Duty Income	(97)	21	2
3	Bank Charges	(903)	21	3
4	Additional R&M	10,786	06	4
5	Non-Allowable Fees	(190,393)	43	5
6	Misc Income	(1,655)	21	6
7	Amortization of Loan Costs	(12,987)	36	7
8	COPE Dues	(3,165)	20	8
9	Non allowable Legal	(464)	19	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
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	(249,878)	49

Plaza Nursing & Rehab Center

ID# 0049858

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Plaza Nursing & Rehab Center# 0049858

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				(6,195)								(6,195)	1
2	Food Purchase	(6)											(6)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(5,959)		640									(5,319)	5
6	Maintenance	10,786		1,122	(13,418)								(1,510)	6
7	Other (specify):*			96	1,129								1,225	7
8	TOTAL General Services	4,821		1,858	(18,484)								(11,805)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				(35,762)								(35,762)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation				1,619								1,619	14
15	Other (specify):*				3,658								3,658	15
16	TOTAL Health Care and Programs				(30,485)								(30,485)	16
	C. General Administration													
17	Administrative			15,187	(9,086)								6,101	17
18	Directors Fees													18
19	Professional Services	(51,464)		(116,861)	(12,777)	190	(1,585)						(182,497)	19
20	Fees, Subscriptions & Promotions	(15,915)		426	1,406	10							(14,073)	20
21	Clerical & General Office Expenses	(150,169)		47,861	11,145	82							(91,081)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			176	368								544	24
25	Other Admin. Staff Transportation			1,638	1,411								3,049	25
26	Insurance-Prop.Liab.Malpractice			841	173								1,014	26
27	Other (specify):*			12,805	4,691								17,496	27
28	TOTAL General Administration	(217,548)		(37,927)	(2,669)	282	(1,585)						(259,447)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(212,727)		(36,069)	(51,638)	282	(1,585)						(301,737)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Plaza Nursing & Rehab Center

0049858

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(25,527)		1,026		2,142							(22,359)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(772)		846		2,004							2,078	32
33	Real Estate Taxes					2,529							2,529	33
34	Rent-Facility & Grounds			(4,584)		(7,416)							(12,000)	34
35	Rent-Equipment & Vehicles			1,104	1,523								2,627	35
36	Other (specify):*	(12,987)											(12,987)	36
37	TOTAL Ownership	(39,286)		(1,608)	1,523	(741)							(40,112)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(25,720)					(25,720)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(192,785)			(6,000)								(198,785)	43
44	TOTAL Special Cost Centers	(192,785)			(6,000)			(25,720)					(224,505)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(444,798)		(37,677)	(56,115)	(459)	(1,585)	(25,720)					(566,354)	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.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	YAM MANAGEMENT, LLC	100.00%	\$ 640	\$	640	15
16	V	6 REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	1,122		1,122	16
17	V	7 EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	96		96	17
18	V	17 ADMINISTRATIVE		YAM MANAGEMENT, LLC	100.00%	15,187		15,187	18
19	V	19 PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	2,742		2,742	19
20	V	20 FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	426		426	20
21	V	21 CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	47,861		47,861	21
22	V	24 SEMINARS		YAM MANAGEMENT, LLC	100.00%	176		176	22
23	V	25 AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	1,638		1,638	23
24	V	26 INSURANCE		YAM MANAGEMENT, LLC	100.00%	841		841	24
25	V	27 EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	12,805		12,805	25
26	V	30 DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	1,026		1,026	26
27	V	32 INTEREST		YAM MANAGEMENT, LLC	100.00%	846		846	27
28	V	33 REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%				28
29	V	34 RENT		YAM MANAGEMENT, LLC	100.00%	7,416		7,416	29
30	V	35 AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	1,104		1,104	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V	19 BOOKKEEPING FEES	83,603	YAM MANAGEMENT, LLC	100.00%			(83,603)	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								38
39	Total		\$ 131,603			\$ 93,926	\$ *	(37,677)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1	DIETARY	YAM CONSULTING, LLC	100.00%	\$ 6,818	\$ 6,818
16	V	7	EMP. BEN. GEN. SERV.	YAM CONSULTING, LLC	100.00%	1,129	1,129
17	V	10	NURSING SALARY	YAM CONSULTING, LLC	100.00%	26,338	26,338
18	V	14	PROGRAM TRANSPORTATION	YAM CONSULTING, LLC	100.00%	1,619	1,619
19	V	15	EMP. BEN. HEALTHCARE	YAM CONSULTING, LLC	100.00%	3,658	3,658
20	V	17	ADMINISTRATIVE	YAM CONSULTING, LLC	100.00%	14,614	14,614
21	V	19	PROFESSIONAL FEES	YAM CONSULTING, LLC	100.00%	791	791
22	V	20	FEES, SUBSCRIPTIONS	YAM CONSULTING, LLC	100.00%	1,406	1,406
23	V	21	CLERICAL & GENERAL	YAM CONSULTING, LLC	100.00%	11,145	11,145
24	V	24	SEMINARS	YAM CONSULTING, LLC	100.00%	368	368
25	V	25	AUTO AND TRAVEL	YAM CONSULTING, LLC	100.00%	1,411	1,411
26	V	27	EMP. BEN.-GEN. ADMIN.	YAM CONSULTING, LLC	100.00%	4,691	4,691
27	V	26	INSURANCE	YAM CONSULTING, LLC	100.00%	173	173
28	V	35	AUTO RENTAL	YAM CONSULTING, LLC	100.00%	1,523	1,523
29	V	6	REPAIRS AND MAINTENANCE SALARY	YAM CONSULTING, LLC	100.00%	2,992	2,992
30	V						
31	V						
32	V	06	PAINTER	YAM CONSULTING, LLC	100.00%		(15,360)
33	V	01	DIETICIAN CONSULTING	YAM CONSULTING, LLC	100.00%		(13,013)
34	V	10	NURSE CONSULTING	YAM CONSULTING, LLC	100.00%		(62,100)
35	V	17	DIR. OF OPERATIONS CONSULT	YAM CONSULTING, LLC	100.00%		(23,700)
36	V	19	DATA PROCESSING FEES	YAM CONSULTING, LLC	100.00%		(13,568)
37	V	43	MARKETING	YAM CONSULTING, LLC	100.00%		(6,000)
38	V	06	PROJECT MANAGER INCOME	YAM CONSULTING, LLC	100.00%		(1,050)
39	Total		\$ 134,791			\$ 78,676	\$ * (56,115)

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19 PROFESSIONAL FEES	\$	8131 N. MONTICELLO, LLC	100.00%	\$ 190	\$	190	15
16	V	20 DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		10		10	16
17	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC		82		82	17
18	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC		2,142		2,142	18
19	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC		2,004		2,004	19
20	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		2,529		2,529	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34 RENT	7,416	8131 N. MONTICELLO, LLC				(7,416)	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		\$ 7,416			\$ 6,957	\$ *	(459)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Payroll Services	\$ 12,194	ProPay HR LLC	66.67%	\$ 10,609	\$ (1,585)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 12,194			\$ 10,609	\$ * (1,585)

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Therapy Services	\$ 160,750	Renewal Rehab	100.00%	\$ 135,030	\$ (25,720)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 160,750			\$ 135,030	\$ * (25,720)

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	Declaration of Trust of Yosef Meystel	41.500%	BERKSHIRE NURSING & REHAB CENTER,LLC	FOREST PARK	YAM MANAGEMENT	SKOKIE	MANAGEMENT CO.	1
2	Joshua Weinstein	3.000%	CONCORD NURSING AND REHABILITATION CENTER,LLC	OAK LAWN	YAM CONSULTING	SKOKIE	CONSULTING CO.	2
3	Christina Inofre	1.000%	DOLTON NURSING & REHAB,LLC	DOLTON	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	3
4	David A. Berkowitz Revocable Trust	39.500%	EXCEPTIONAL CARE, LLC	BURBANK	PROPAY	EVANSTON	PAYROLL SERVICES	4
5	42170 Limited Partnership	2.250%	HIGHLAND PARK NURSING AND REHAB CENTER, LLC	HIGHWOOD	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	5
6	1219 Limited Partnership	2.250%	INTERNATIONAL NURSING & REHAB CENTER,LLC	CHICAGO	ROOSEVELT RISK MANAGEME	SKOKIE	CAPTIVE INSURANCE	6
7	257 Limited Partnership	3.500%	LITCHFIELD CARE CENTER,LLC	LITCHFIELD				7
8	George Lowinger	7.000%	NORTH CHURCH NURSING & REHAB,LLC	JACKSONVILLE				8
9			EVANSTON NURSING & REHAB	EVANSTON				9
10			PLUM GROVE NURSING AND REHAB,LLC	PALATINE				10
11			RIVIERA CARE CENTER,LLC	CHICAGO HEIGHTS				11
12			SPRINGFIELD CARE CENTER,LLC	SPRINGFIELD				12
13			THE ARBORS AT MICHIGAN CITY	MICHIGAN CITY,IN				13
14			THE COPPERAS HOLLOW	CALDWELL, TX				14
15			ISLAND CITY REHAB CENTER	WILMINGTON				15
16			LINCOLN REHAB	DECATUR				16
17			RIVERWOOD REHAB	EAST MOLINE				17
18			RIVER CROSSING REHAB	GALESBURG				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 Plaza Nursing & Rehab Center

0049858

Report Period Beginning:

01/01/13

Ending:

12/31/13

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 Plaza Nursing & Rehab Center # 0049858 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Relative	Administrative	0.00%	See Attached	1.6	4.00%	Mgmt. Fees	\$ 10,225	17-03	1
2	Cynthia Meystel	Relative	Clerical	0.00%	See Attached	0.1	3.03%	Alloc. Salary	749	21-07	2
3	David Berkowitz	Relative	Administrative	0.00%	See Attached	1.6	4.00%	Mgmt. Fees	12,201	17-03	3
4	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.8	2.00%	Alloc. Salary	2,486	17-07	4
5	Joel Meystel	Relative	Administrative	0.00%	See Attached	0.8	2.00%	Alloc. Salary	1,021	17-07	5
6	Christina Inofre	Owner	Nursing	1.00%	See Attached	1.6	4.00%	Alloc. Salary	4,533	10-07	6
7	Meir Meystel	Relative	Administrative	0.00%	See Attached	0	35.00%	Conslt. Fees	6,000	19-03	7
8	George Lowinger	Owner	Administrative	7.00%	See Attached	0	0.00%	Mgmt. Fees	8,250	17-03	8
9	Shimon Meystel	Relative	Clerical	0.00%	See Attached	1.6	4.00%	Alloc. Salary	353	21-07	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	\$ 45,818		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 Plaza Nursing & Rehab Center

0049858

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plaza Nursing & Rehab Center

0049858

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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	5	UTILITIES	AVAIL. BED DAYS	806,222	20	\$ 15,532	\$ 33,215	\$ 640	1	
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	806,222	20	27,235	10,706	33,215	1,122	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	806,222	20	2,325		33,215	96	3
4	17	ADMINISTRATIVE	AVAIL. BED DAYS	806,222	20	368,628	368,628	33,215	15,187	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	806,222	20	66,554		33,215	2,742	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	806,222	20	10,341		33,215	426	6
7	21	CLERICAL & GENERAL	AVAIL. BED DAYS	806,222	20	1,161,730	1,062,779	33,215	47,861	7
8	24	SEMINARS	AVAIL. BED DAYS	806,222	20	4,271		33,215	176	8
9	25	AUTO AND TRAVEL	AVAIL. BED DAYS	806,222	20	39,751		33,215	1,638	9
10	26	INSURANCE	AVAIL. BED DAYS	806,222	20	20,417		33,215	841	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	806,222	20	310,817		33,215	12,805	11
12	30	DEPRECIATION	AVAIL. BED DAYS	806,222	20	24,916		33,215	1,026	12
13	32	INTEREST	AVAIL. BED DAYS	806,222	20	20,530		33,215	846	13
14	33	REAL ESTATE TAX	AVAIL. BED DAYS	806,222	20	-		33,215		14
15	34	RENT	AVAIL. BED DAYS	806,222	20	180,000		33,215	7,416	15
16	35	AUTO RENTAL	AVAIL. BED DAYS	806,222	20	26,797		33,215	1,104	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,279,844	\$ 1,442,113		\$ 93,926	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plaza Nursing & Rehab Center

0049858

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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	806,222	20	\$ 165,484	\$ 152,992	33,215	\$ 6,818	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	806,222	20	27,395		33,215	1,129	2
3	10	NURSING SALARY	AVAIL. BED DAYS	806,222	20	639,288	639,288	33,215	26,338	3
4	14	PROGRAM TRANSPORTATION	AVAIL. BED DAYS	806,222	20	39,307		33,215	1,619	4
5	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	806,222	20	88,801		33,215	3,658	5
6	17	ADMINISTRATIVE	AVAIL. BED DAYS	806,222	20	354,711	354,711	33,215	14,614	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	806,222	20	19,212		33,215	791	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	806,222	20	34,122		33,215	1,406	8
9	21	CLERICAL & GENERAL	AVAIL. BED DAYS	806,222	20	270,517	258,772	33,215	11,145	9
10	24	SEMINARS	AVAIL. BED DAYS	806,222	20	8,935		33,215	368	10
11	25	AUTO AND TRAVEL	AVAIL. BED DAYS	806,222	20	34,250		33,215	1,411	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	806,222	20	113,873		33,215	4,691	12
13	26	INSURANCE	AVAIL. BED DAYS	806,222	20	4,192		33,215	173	13
14	35	AUTO RENTAL	AVAIL. BED DAYS	806,222	20	36,968		33,215	1,523	14
15	6	REPAIRS AND MAINTENANCE	AVAIL. BED DAYS	806,222	20	72,622	72,622	33,215	2,992	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,909,677	\$ 1,478,385		\$ 78,676	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plaza Nursing & Rehab Center

0049858

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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	806,222	20	\$ 4,605	\$ 37,960	\$ 190	1
2	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	806,222	20	250	37,960	10	2
3	21	OFFICE EXPENSE	AVAIL. BED DAYS	806,222	20	2,000	37,960	82	3
4	30	DEPRECIATION	AVAIL. BED DAYS	806,222	20	51,991	37,960	2,142	4
5	32	INTEREST EXPENSE	AVAIL. BED DAYS	806,222	20	48,653	37,960	2,004	5
6	33	REAL ESTATE TAXES	AVAIL. BED DAYS	806,222	20	61,377	37,960	2,529	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					\$ 168,876	\$	\$ 6,957	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plaza Nursing & Rehab Center

0049858

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization ProPay HR LLC
 Street Address 2201 W MAIN STREET
 City / State / Zip Code EVANSTON, ILLINOIS 60202
 Phone Number (847) 905-3268
 Fax Number ()

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	Payorll Services	Direct		\$	\$		\$ 10,609	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				\$	\$		\$ 10,609	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plaza Nursing & Rehab Center

0049858

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 RENEWAL REHAB
 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	39	Renewal Rehab	Direct		\$	\$		\$ 135,030	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				\$	\$		\$ 135,030	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plaza Nursing & Rehab Center

0049858

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plaza Nursing & Rehab Center

0049858 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Plaza Nursing & Rehab Center

0049858

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plaza Nursing & Rehab Center

0049858

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plaza Nursing & Rehab Center # 0049858 Report Period Beginning: 01/01/13 Ending: 12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1						\$				\$	1							
2											2							
3											3							
4											4							
5											5							
Working Capital																		
6	First Bank		X	Line of Credit			657,981			34,923	6							
7	Insurance Policies		X							2,143	7							
8	See Supplemental Schedule									2,850	8							
9	TOTAL Facility Related					\$	\$ 657,981			\$ 39,916	9							
B. Non-Facility Related*																		
10	Interest Income									(772)	10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			(772)	14							
15	TOTALS (line 9+line14)					\$	\$ 657,981			\$ 39,144	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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 Plaza Nursing & Rehab Center

0049858

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$					
2																
3																
4																
5																
6																
7	TOTAL Long-Term															
	Working Capital															
8	Allocated from YAM Management						\$	\$			\$ 846					
9	Allocated from 8131 N. Monticello										2,004					
10																
11																
12																
13																
14	TOTAL Working Capital										2,850					
	B. Non-Facility Related*															
15							\$	\$			\$					
16																
17																
18																
19																
20	TOTAL Non-Facility Related															

* 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 Plaza Nursing & Rehab Center# 0049858

Report Period Beginning:

01/01/13

Ending:

12/31/13

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 2012 report.	\$	<u>129,218</u>		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.)	\$	<u>140,030</u>		2
3.	Under or (over) accrual (line 2 minus line 1).	\$	<u>10,812</u>		3
4.	Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<u>138,000</u>		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.)	\$	<u>10,440</u>		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 \$ <u>30,768</u> For <u>2010</u> 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.	\$	<u>159,252</u>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
	2008	<u>94,751</u>	<u>8</u>	FOR BHF USE ONLY	
	2009	<u>121,574</u>	<u>9</u>		
	2010	<u>122,517</u>	<u>10</u>	13	FROM R. E. TAX STATEMENT FOR 2012 \$ 13
	2011	<u>129,219</u>	<u>11</u>	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2012	<u>137,501</u>	<u>12</u>	15	LESS REFUND FROM LINE 6 \$ 15
<u>2013 Accrual = 2012 Tax</u>				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
<u>Allocated from 8131 N. Monticello- \$2,529</u>					

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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Plaza Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049858

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(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>28-11-408-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>132,243.10</u>	\$ <u>132,243.10</u>
2. <u>28-11-408-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>2,700.84</u>	\$ <u>2,700.84</u>
3. <u>28-11-408-050-0000</u>	<u>Long Term Care Property</u>	\$ <u>2,557.27</u>	\$ <u>2,557.27</u>
4. <u>See Attached</u>	<u>Allocated from 8131 N. Monticello</u>	\$ <u>70,066.20</u>	\$ <u>2,528.63</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>207,567.41</u></u>	\$ <u><u>140,029.84</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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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.**

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,780 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).

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Allocated from 8131 Monticello		2010	\$ 3,667	1
2					2
3	TOTALS			\$ 3,667	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2008		50,558		20	4,546	4,546	24,835	9
10	Various		2009		43,854		20	3,887	3,887	17,450	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			45,838	2,343	1,682	(661)	5,435	68
69				67,004		(67,004)		69
70			\$ 140,250	\$ 69,347		\$ 10,115	\$ (59,232)	\$ 47,720 70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Plaza Nursing & Rehab Center

0049858

Report Period Beginning:

01/01/13

Ending:

12/31/13

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		\$ 140,250	\$ 69,347		\$ 10,115	\$ (59,232)	\$ 47,720	1
2	Corridor Handrails/Bumper Guards	2010	26,339		20	1,757	1,757	6,148	2
3	John Deere Generator	2010	39,278		20	2,620	2,620	9,167	3
4	Panel Remote Annunciator	2010	6,603		20	440	440	1,541	4
5	Panic Devices And Handles	2010	2,929		20	195	195	684	5
6	Connection To Generator	2010	9,750		20	650	650	2,276	6
7	Install Door/ Carpentry	2010	6,056		20	404	404	1,413	7
8	Acoustical Ceiling Suspension	2010	4,910		20	328	328	1,146	8
9	36" Fire Rated Door	2010	2,950		20	197	197	689	9
10	36" Fire Rated Door	2010	3,450		20	230	230	805	10
11	Tuck Pointing, Chimney Repairs, Rebuild Retaining Wall	2010	10,950		20	548	548	1,916	11
12	Repairs To Hydro-Jet And Pump Basins	2010	2,500		20	125	125	396	12
13	Code Violations - Architect	2010	5,764		20	288	288	913	13
14	Window A/C Units	2011	22,252		20	1,113	1,113	3,152	14
15	Fire Sprinkler System	2011	76,911		20	3,846	3,846	9,934	15
16	Backflow Devices	2011	12,827		20	641	641	1,710	16
17	Backflow Devices	2011	12,827		20	641	641	1,710	17
18	Notifier System	2011	14,402		20	720	720	1,740	18
19	Nurse Call Station	2011	18,943		20	947	947	2,131	19
20	Security Cameras	2011	15,656		20	783	783	1,761	20
21	3.5 Ton Hvac System	2011	60,850		20	3,043	3,043	8,874	21
22	Sewer Pipe	2011	3,450		20	173	173	388	22
23	New Roof & Rafters	2011	7,165		20	358	358	746	23
24	Repairs To Ceiling, Walls In Boiler Room & Dishwasher Room	2011	3,654		20	183	183	381	24
25	New Garage/Roof	2012	3,754		20	375	375	657	25
26	Mechanical Room - Heaters, Thermostat, Intake Louvers, Ductwo	2012	17,500		20	1,167	1,167	1,313	26
27	Shingle Roof	2012	3,550		20	355	355	710	27
28	Hot Water Tank / Flu Pipe	2012	5,094		20	382	382	764	28
29	Engineering Services	2013	6,210		20	207	207	207	29
30	Repavement	2013	3,860		20	86	86	86	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 550,634	\$ 69,347		\$ 32,917	\$ (36,430)	\$ 111,078	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	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 12B, Carried Forward		\$ 550,634	\$ 69,347		\$ 32,917	\$ (36,430)	\$ 111,078	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)		\$ 550,634	\$ 69,347		\$ 32,917	\$ (36,430)	\$ 111,078	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	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 12C, Carried Forward		\$ 550,634	\$ 69,347		\$ 32,917	\$ (36,430)	\$ 111,078	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)		\$ 550,634	\$ 69,347		\$ 32,917	\$ (36,430)	\$ 111,078	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 550,634	\$ 69,347		\$ 32,917	\$ (36,430)	\$ 111,078	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)		\$ 550,634	\$ 69,347		\$ 32,917	\$ (36,430)	\$ 111,078	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	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	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	28,490	847	35	731	(116)	2,526	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from YAM Management	2010	1,357	136	20	136		444	9
10	Allocated from YAM Management	2012	857	57	20	57		87	10
11	Allocated from YAM Management	2013	152	9	20	9		9	11
12	Allocated from 8131 N. Monticello	2010	12,762	1,276	20	638	(638)	2,258	12
13	Allocated from 8131 N. Monticello	2013	2,220	18	20	111	93	111	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 Plaza Nursing & Rehab Center

0049858

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	Related Party Information Continued		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 45,838	\$ 2,343		\$ 1,682	\$ (661)	\$ 5,435	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Plaza Nursing & Rehab Center

0049858

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	\$ 37,754	\$ 431	\$ 5,575	\$ 5,144	10	\$ 28,525	71
72	Current Year Purchases	13,295	95	2,315	2,220	10	2,315	72
73	Fully Depreciated Assets	1,234				10	1,234	73
74								74
75	TOTALS	\$ 52,283	\$ 526	\$ 7,890	\$ 7,364		\$ 32,074	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		2009 GMC SAVANA	2011	\$ 23,542	\$	\$ 3,539	\$ 3,539	5	\$ 10,565	76
77		Allocated from YAM Managemen	2011	1,401	299	299		5	704	77
78										78
79										79
80	TOTALS			\$ 24,943	\$ 299	\$ 3,838	\$ 3,539		\$ 11,269	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)	\$ 631,527	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 70,172	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 44,645	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (25,527)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 154,421	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plaza Nursing & Rehab Center

0049858

Report Period Beginning: 01/01/13

Ending: 12/31/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Plaza Terrace Property, LLC

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:		91		\$ 443,392			3
4	Additions							4
5								5
6								6
7	TOTAL		91		\$ 443,392			7

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 1,790 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 Consulting		\$ _____	\$ 1,523	17
18	Allocated from YAM Management			1,104	18
19					19
20					20
21	TOTAL		\$ _____	\$ 2,627	21

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	97,682	\$		\$	97,682	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				12,975				12,975	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				104,577				104,577	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					110,099			110,099	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>						11,470	712			12,182	13
14	TOTAL			\$		\$	226,704	\$	110,811	\$	337,515	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 Plaza Nursing & Rehab Center# 0049858Report Period Beginning: 01/01/13

Ending:

12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(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	\$ 41,821	\$	1
2	Cash-Patient Deposits	(75,187)		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	845,870		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	66,142		6
7	Other Prepaid Expenses	464		7
8	Accounts Receivable (owners or related parties)	320,000		8
9	Other(specify): <u>See Attached Schedule</u>	37,215		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,236,325	\$	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	530,035		15
16	Equipment, at Historical Cost	107,452		16
17	Accumulated Depreciation (book methods)	(222,587)		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>	150,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 564,900	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,801,225	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 243,115	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(75,257)		28
29	Short-Term Notes Payable	657,981		29
30	Accrued Salaries Payable	131,750		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,654		31
32	Accrued Real Estate Taxes(Sch.IX-B)	138,000		32
33	Accrued Interest Payable	3,062		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	71,652		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,176,957	\$	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				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,176,957	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 624,268	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,801,225	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 612,102	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 612,102	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	116,788	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	(104,622)	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)	\$ 12,166	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)	\$ 624,268	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,905,054	1
2	Discounts and Allowances for all Levels	(1,720,453)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,184,601	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	644,879	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 644,879	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	93,697	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,716	19
20	Radiology and X-Ray	120	20
21	Other Medical Services	3,810	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 104,343	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	33,292	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 33,292	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,967,115	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	706,148	31
32	Health Care	1,565,321	32
33	General Administration	1,139,701	33
B. Capital Expense			
34	Ownership	720,521	34
C. Ancillary Expense			
35	Special Cost Centers	536,300	35
36	Provider Participation Fee	182,336	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,850,327	40
41	Income before Income Taxes (line 30 minus line 40)**	116,788	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 116,788	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,870,794	44
45	Private Pay - Net Inpatient Revenue	32,390	45
46	Medicare - Net Inpatient Revenue	273,147	46
47	Other-(specify) <u>Insurance</u>	8,270	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,184,601	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plaza Nursing & Rehab Center

0049858

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	2,008	2,132	\$ 93,615	\$ 43.91	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,682	6,176	182,006	29.47	3
4	Licensed Practical Nurses	17,128	18,666	486,259	26.05	4
5	CNAs & Orderlies	32,865	36,672	404,834	11.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,053	3,393	57,541	16.96	8
9	Activity Director	1,992	2,158	30,812	14.28	9
10	Activity Assistants	2,718	2,992	37,551	12.55	10
11	Social Service Workers	4,505	4,874	73,030	14.98	11
12	Dietician					12
13	Food Service Supervisor	1,992	2,080	43,480	20.90	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,956	13,410	125,686	9.37	15
16	Dishwashers					16
17	Maintenance Workers	4,000	4,182	68,423	16.36	17
18	Housekeepers	10,988	11,928	122,335	10.26	18
19	Laundry					19
20	Administrator	1,984	2,080	92,962	44.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,772	6,376	67,203	10.54	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	688	761	8,773	11.53	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,912	1,984	20,945	10.56	33
34	TOTAL (lines 1 - 33)	109,243	119,864	\$ 1,915,455 *	\$ 15.98	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	237	\$ 13,013	01-03	35
36	Medical Director	Monthly	18,244	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	832	62,100	10-03	38
39	Pharmacist Consultant	Monthly	7,509	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	2,135	11-03	44
45	Social Service Consultant	110	6,352	12-03	45
46	Other(specify) <u>Psychiatric MD</u>	Monthly	9,000	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,214	\$ 118,353		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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
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9												
10												
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14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plaza Nursing & Rehab Center

0049858

Report Period Beginning:

01/01/13

Ending:

12/31/13

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. ILCLTC \$ 9,591
- (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. \$ 6,866 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. \$ 182,336
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ N/A 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? 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. \$ 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.