

Facility Name & ID Number Springfield Care Center

0051086 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	65	Intermediate (ICF)	65	23,725	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	65	TOTALS	65	23,725	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	3 Private Pay	4 Other	4 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	21,788	811	21	22,620	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,788	811	21	22,620	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.34%

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 09/01/2010

J. Was the facility purchased or leased after January 1, 1978?

YES Date 09/01/2010 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	112,683	12,256	7,287	132,226		132,226	4,870	137,096		1
2	Food Purchase		97,740		97,740		97,740	(35)	97,705		2
3	Housekeeping	93,938	6,667	388	100,993		100,993		100,993		3
4	Laundry	295	7,307		7,602		7,602		7,602		4
5	Heat and Other Utilities			65,191	65,191		65,191	(3,011)	62,180		5
6	Maintenance	34,927	15,904	25,895	76,726		76,726	2,999	79,725		6
7	Other (specify):*							874	874		7
8	TOTAL General Services	241,843	139,874	98,761	480,478		480,478	5,697	486,175		8
	B. Health Care and Programs										
9	Medical Director			13,200	13,200		13,200		13,200		9
10	Nursing and Medical Records	654,679	25,852	27,988	708,519		708,519	(87)	708,432		10
10a	Therapy										10a
11	Activities	28,271	3,002	2,797	34,070		34,070		34,070		11
12	Social Services	79,678		3,287	82,965		82,965		82,965		12
13	CNA Training										13
14	Program Transportation							1,157	1,157		14
15	Other (specify):*							2,613	2,613		15
16	TOTAL Health Care and Programs	762,628	28,854	47,272	838,754		838,754	3,683	842,437		16
	C. General Administration										
17	Administrative	59,972		42,689	102,661		102,661	(16,714)	85,947		17
18	Directors Fees										18
19	Professional Services			131,729	131,729		131,729	(73,789)	57,940		19
20	Dues, Fees, Subscriptions & Promotions			30,882	30,882		30,882	(8,589)	22,293		20
21	Clerical & General Office Expenses	21,884		51,268	73,152		73,152	10,416	83,568		21
22	Employee Benefits & Payroll Taxes			141,007	141,007		141,007		141,007		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,814	1,814		1,814	389	2,203		24
25	Other Admin. Staff Transportation			14,047	14,047		14,047	2,178	16,225		25
26	Insurance-Prop.Liab.Malpractice			37,141	37,141		37,141	724	37,865		26
27	Other (specify):*							12,498	12,498		27
28	TOTAL General Administration	81,856		450,577	532,433		532,433	(72,887)	459,546		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,086,327	168,728	596,610	1,851,665		1,851,665	(63,507)	1,788,158		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 Springfield Care Center

#0051086

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			51,128	51,128	51,128	28,674	79,802				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,916	7,916	7,916	43,563	51,479				32
33	Real Estate Taxes						19,128	19,128				33
34	Rent-Facility & Grounds			184,079	184,079	184,079	(184,079)					34
35	Rent-Equipment & Vehicles			4,487	4,487	4,487	1,877	6,364				35
36	Other (specify):*			4,123	4,123	4,123	(4,123)	(0)				36
37	TOTAL Ownership			251,733	251,733	251,733	(94,960)	156,773				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			138,790	138,790	138,790		138,790				42
43	Other (specify):*			58,178	58,178	58,178	(58,178)	0				43
44	TOTAL Special Cost Centers			196,968	196,968	196,968	(58,178)	138,790				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,086,327	168,728	1,045,311	2,300,366	2,300,366	(216,645)	2,083,721				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 Springfield Care Center

0051086

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	(3,468)	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	(21,200)	30		9
10	Interest and Other Investment Income	(8)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(35)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,118)	21		18
19	Entertainment	(2,700)	21		19
20	Contributions	(8,450)	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	(3,470)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(87,556)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (128,005)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(88,640)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (88,640)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (216,645)		37

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

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

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

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Springfield Care Center

ID# 0051086

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Advertising/Marketing	\$ (2,112)	43	1
2	Bank Charges	(22,893)	21	2
3	Theft & Damage	(1,611)	21	3
4	Amortization	(4,123)	36	4
5	Bldg. Co. - Bank Charges	(321)	21	5
6	Bldg. Co. - Licenses & Permits	(275)	20	6
7	Additional R&M	5,161	06	7
8	COPE Dues	(1,454)	20	8
9	Non-Allowable Legal Fees	(563)	19	9
10	Capitalized R&M	(4,800)	06	10
11	Non-allowable Expense	(54,566)	43	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	(87,556)	49

Springfield Care Center

ID# 0051086

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 Springfield Care Center# 0051086

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				4,870								4,870	1
2	Food Purchase	(35)											(35)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(3,468)		457									(3,011)	5
6	Maintenance	361		801	1,837								2,999	6
7	Other (specify):*			68	806								874	7
8	TOTAL General Services	(3,142)		1,326	7,513								5,697	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				(87)								(87)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation				1,157								1,157	14
15	Other (specify):*				2,613								2,613	15
16	TOTAL Health Care and Programs				3,683								3,683	16
	C. General Administration													
17	Administrative			10,848	(27,562)								(16,714)	17
18	Directors Fees													18
19	Professional Services	(563)	(1,250)	(68,343)	(2,685)	136	(1,084)						(73,789)	19
20	Fees, Subscriptions & Promotions	(10,179)	275	304	1,004	7							(8,589)	20
21	Clerical & General Office Expenses	(32,112)	321	34,187	7,961	59							10,416	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			126	263								389	24
25	Other Admin. Staff Transportation			1,170	1,008								2,178	25
26	Insurance-Prop.Liab.Malpractice			601	123								724	26
27	Other (specify):*			9,147	3,351								12,498	27
28	TOTAL General Administration	(42,854)	(654)	(11,960)	(16,537)	202	(1,084)						(72,887)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(45,996)	(654)	(10,634)	(5,341)	202	(1,084)						(63,507)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Springfield Care Center

0051086

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	(21,200)	47,611	733		1,530							28,674	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(8)	41,535	604		1,432							43,563	32
33	Real Estate Taxes		17,322			1,806							19,128	33
34	Rent-Facility & Grounds		(172,079)	(6,703)		(5,297)							(184,079)	34
35	Rent-Equipment & Vehicles			789	1,088								1,877	35
36	Other (specify):*	(4,123)											(4,123)	36
37	TOTAL Ownership	(25,331)	(65,611)	(4,577)	1,088	(529)							(94,960)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(56,678)			(1,500)								(58,178)	43
44	TOTAL Special Cost Centers	(56,678)			(1,500)								(58,178)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(128,005)	(66,265)	(15,211)	(5,753)	(327)	(1,084)						(216,645)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 172,079	Centralia Property, LLC	100.00%	\$	\$ (172,079)	1
2	V	21 Bank Charges		Centralia Property, LLC	100.00%	321	321	2
3	V	20 Licenses & Permits		Centralia Property, LLC	100.00%	275	275	3
4	V	30 Depreciation		Centralia Property, LLC	100.00%	47,611	47,611	4
5	V	33 Real Estate Taxes		Centralia Property, LLC	100.00%	17,322	17,322	5
6	V	32 Interest Expense		Centralia Property, LLC	100.00%	41,535	41,535	6
7	V	19 Accounting	1,250	Centralia Property, LLC	100.00%		(1,250)	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 173,329			\$ 107,064	\$ * (66,265)	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%	\$ 457	\$	457	15
16	V	6 REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	801		801	16
17	V	7 EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	68		68	17
18	V	17 ADMINISTRATIVE		YAM MANAGEMENT, LLC	100.00%	10,848		10,848	18
19	V	19 PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	1,959		1,959	19
20	V	20 FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	304		304	20
21	V	21 CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	34,187		34,187	21
22	V	24 SEMINARS		YAM MANAGEMENT, LLC	100.00%	126		126	22
23	V	25 AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	1,170		1,170	23
24	V	26 INSURANCE		YAM MANAGEMENT, LLC	100.00%	601		601	24
25	V	27 EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	9,147		9,147	25
26	V	30 DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	733		733	26
27	V	32 INTEREST		YAM MANAGEMENT, LLC	100.00%	604		604	27
28	V	33 REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%				28
29	V	34 RENT		YAM MANAGEMENT, LLC	100.00%	5,297		5,297	29
30	V	35 AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	789		789	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V	19 BOOKKEEPING FEES	55,295	YAM MANAGEMENT, LLC	100.00%			(55,295)	35
36	V	19 ACCOUNTING	12,000	YAM MANAGEMENT, LLC	100.00%			(12,000)	36
37	V	34 RENT	12,000	YAM MANAGEMENT, LLC	100.00%			(12,000)	37
38	V	19 PROFESSIONAL FEES	3,007	YAM MANAGEMENT, LLC	100.00%			(3,007)	38
39	Total		\$ 82,302			\$ 67,091	\$ *	(15,211)	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%	\$ 4,870	\$ 4,870
16	V	7	EMP. BEN. GEN. SERV.	YAM CONSULTING, LLC	100.00%	806	806
17	V	10	NURSING SALARY	YAM CONSULTING, LLC	100.00%	18,813	18,813
18	V	14	PROGRAM TRANSPORTATION	YAM CONSULTING, LLC	100.00%	1,157	1,157
19	V	15	EMP. BEN. HEALTHCARE	YAM CONSULTING, LLC	100.00%	2,613	2,613
20	V	17	ADMINISTRATIVE	YAM CONSULTING, LLC	100.00%	10,438	10,438
21	V	19	PROFESSIONAL FEES	YAM CONSULTING, LLC	100.00%	565	565
22	V	20	FEES, SUBSCRIPTIONS	YAM CONSULTING, LLC	100.00%	1,004	1,004
23	V	21	CLERICAL & GENERAL	YAM CONSULTING, LLC	100.00%	7,961	7,961
24	V	24	SEMINARS	YAM CONSULTING, LLC	100.00%	263	263
25	V	25	AUTO AND TRAVEL	YAM CONSULTING, LLC	100.00%	1,008	1,008
26	V	27	EMP. BEN.-GEN. ADMIN.	YAM CONSULTING, LLC	100.00%	3,351	3,351
27	V	26	INSURANCE	YAM CONSULTING, LLC	100.00%	123	123
28	V	35	AUTO RENTAL	YAM CONSULTING, LLC	100.00%	1,088	1,088
29	V	6	REPAIRS AND MAINTENANCE SALARY	YAM CONSULTING, LLC	100.00%	2,137	2,137
30	V						
31	V						
32	V						
33	V						
34	V	10	NURSE CONSULTING	YAM CONSULTING, LLC	100.00%		(18,900)
35	V	17	DIR. OF OPERATIONS CONSULT	YAM CONSULTING, LLC	100.00%		(38,000)
36	V	19	DATA PROCESSING FEES	YAM CONSULTING, LLC	100.00%		(3,250)
37	V	43	MARKETING	YAM CONSULTING, LLC	100.00%		(1,500)
38	V	06	PROJECT MANAGER INCOME	YAM CONSULTING, LLC	100.00%		(300)
39	Total		\$ 61,950			\$ 56,197	\$ * (5,753)

* 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%	\$ 136	\$	136	15
16	V	20 DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		7		7	16
17	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC		59		59	17
18	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC		1,530		1,530	18
19	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC		1,432		1,432	19
20	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		1,806		1,806	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34 RENT	5,297	8131 N. MONTICELLO, LLC				(5,297)	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		\$ 5,297			\$ 4,970	\$ *	(327)	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	\$ 8,340	ProPay HR LLC	66.67%	\$ 7,256	\$ (1,084)
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		\$ 8,340			\$ 7,256	\$ * (1,084)

* 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 (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:	
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	ML EQUITY PARTNERS LLC	5.00%	BERKSHIRE NURSING & REHAB CENTER,LLC	FOREST PARK	YAM MANAGEMENT	SKOKIE	MANAGEMENT CO.	1
2	MARTIN LOEB	2.00%	CONCORD NURSING AND REHABILITATION CENTER,LLC	OAK LAWN	YAM CONSULTING	SKOKIE	CONSULTING CO.	2
3	HOWARD SUSS	5.00%	DOLTON NURSING & REHAB,LLC	DOLTON	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	3
4	DAVID BERKOWITZ	36.50%	EVANSTON NURSING & REHAB CENTER, LLC	EVANSTON	CENTRALIA PROPERTY, LLC	SKOKIE	BUILDING CO.	4
5	DECLARATION OF TRUST OF YOSEF MEYSTEL	34.50%	EXCEPTIONAL CARE, LLC	BURBANK	PROPAY	EVANSTON	PAYROLL SERVICES	5
6	JAY MEYSTEL TRUST	4.00%	HIGHLAND PARK NURSING AND REHAB CENTER, LLC	HIGHWOOD	ROSSEVELT RISK MANAGEME	SKOKIE	CAPTIVE INSURANCE	6
7	STEVEN TUROFSKY	1.00%	INTERNATIONAL NURSING & REHAB CENTER,LLC	CHICAGO				7
8	FREDERICK S. FRANKEL	1.00%	LITCHFIELD CARE CENTER,LLC	LITCHFIELD				8
9	CHRISTINA INOFRE	1.00%	NORTH CHURCH NURSING & REHAB,LLC	JACKSONVILLE				9
10	42170 LIMITED PARTNERSHIP	2.50%	PLAZA NURSING AND REHAB CENTER,LLC	MIDLOTHIAN				10
11	1219 LIMITED PARTNERSHIP	2.50%	PLUM GROVE NURSING AND REHAB,LLC	PALATINE				11
12	257 LTD. PARTNERSHIP	2.50%	RIVIERA CARE CENTER,LLC	CHICAGO HEIGHTS				12
13	417A, LLC	2.50%	THE ARBOR	MICHIGAN CITY, IN				13
14			COPPERAS HOLLOW	CALDWELL, TX				14
15			ISLAND CITY REHAB CENTER	WILMINGTON				15
16			RIVERWOOD REHAB	EAST MOLINE				16
17			RIVER CROSSING REHAB	GALESBURG				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 Springfield Care Center

0051086

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 Springfield Care Center # 0051086 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		See Attached	1.2	3.00%	Mgmt Fees	\$ 2,040	17-3	1
2	David Berkowitz	Owner	Administrative	37%	See Attached	1.2	3%	Mgmt Fees	2,649	17-3	2
3	Joel Meystel	Relative	Administrative		See Attached	0.6	3%	Alloc. Salary	729	17-7	3
4	Jay Meystel	Relative	Administrative		See Attached	0.6	2%	Alloc. Salary	1,776	17-7	4
5	Fred Frankel	Owner	Administrative	1%	See Attached	1.2	3%	Alloc. Salary	4,456	17-7	5
6	Steve Turofsky	Owner	Administrative	1%	See Attached	1.2	3%	Alloc. Salary	3,887	17-7	6
7	Christina Inofre	Owner	Nursing	1%	See Attached	1.2	3%	Alloc. Salary	3,238	10-7	7
8	Cynthia Meystel	Relative	Clerical		See Attached	0.1	3%	Alloc. Salary	535	21-7	8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts anticipated to be considered allowable by the IL. Dept. of HFS.										11
12											12
13	TOTAL								\$ 19,310		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 Springfield Care Center

0051086 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 Springfield Care Center

0051086 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 YAM MANAGEMENT, LLC
 Street Address 8131 N. MONTICELLO
 City / State / Zip Code SKOKIE, ILLINOIS 60076
 Phone Number (847) 673-6767
 Fax Number (847) 673-6768

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. BED DAYS	806,222	20	\$ 15,532	\$ 23,725	\$ 457	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	806,222	20	27,235	10,706	23,725	801
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	806,222	20	2,325	23,725	68	3
4	17	ADMINISTRATIVE	AVAIL. BED DAYS	806,222	20	368,628	368,628	23,725	10,848
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	806,222	20	66,554	23,725	1,959	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	806,222	20	10,341	23,725	304	6
7	21	CLERICAL & GENERAL	AVAIL. BED DAYS	806,222	20	1,161,730	1,062,779	23,725	34,187
8	24	SEMINARS	AVAIL. BED DAYS	806,222	20	4,271	23,725	126	8
9	25	AUTO AND TRAVEL	AVAIL. BED DAYS	806,222	20	39,751	23,725	1,170	9
10	26	INSURANCE	AVAIL. BED DAYS	806,222	20	20,417	23,725	601	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	806,222	20	310,817	23,725	9,147	11
12	30	DEPRECIATION	AVAIL. BED DAYS	806,222	20	24,916	23,725	733	12
13	32	INTEREST	AVAIL. BED DAYS	806,222	20	20,530	23,725	604	13
14	33	REAL ESTATE TAX	AVAIL. BED DAYS	806,222	20	-	23,725		14
15	34	RENT	AVAIL. BED DAYS	806,222	20	180,000	23,725	5,297	15
16	35	AUTO RENTAL	AVAIL. BED DAYS	806,222	20	26,797	23,725	789	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	\$ 67,091	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center

0051086 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	23,725	\$ 4,870	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	806,222	20	27,395	23,725	806		2
3	10	NURSING SALARY	AVAIL. BED DAYS	806,222	20	639,288	639,288	18,813		3
4	14	PROGRAM TRANSPORTATION	AVAIL. BED DAYS	806,222	20	39,307	23,725	1,157		4
5	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	806,222	20	88,801	23,725	2,613		5
6	17	ADMINISTRATIVE	AVAIL. BED DAYS	806,222	20	354,711	354,711	10,438		6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	806,222	20	19,212	23,725	565		7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	806,222	20	34,122	23,725	1,004		8
9	21	CLERICAL & GENERAL	AVAIL. BED DAYS	806,222	20	270,517	258,772	7,961		9
10	24	SEMINARS	AVAIL. BED DAYS	806,222	20	8,935	23,725	263		10
11	25	AUTO AND TRAVEL	AVAIL. BED DAYS	806,222	20	34,250	23,725	1,008		11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	806,222	20	113,873	23,725	3,351		12
13	26	INSURANCE	AVAIL. BED DAYS	806,222	20	4,192	23,725	123		13
14	35	AUTO RENTAL	AVAIL. BED DAYS	806,222	20	36,968	23,725	1,088		14
15	6	REPAIRS AND MAINTENANCE	AVAIL. BED DAYS	806,222	20	72,622	72,622	2,137		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	\$ 56,197		25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center

0051086

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	\$ 136	1
2	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	806,222	20	250	37,960	7	2
3	21	OFFICE EXPENSE	AVAIL. BED DAYS	806,222	20	2,000	37,960	59	3
4	30	DEPRECIATION	AVAIL. BED DAYS	806,222	20	51,991	37,960	1,530	4
5	32	INTEREST EXPENSE	AVAIL. BED DAYS	806,222	20	48,653	37,960	1,432	5
6	33	REAL ESTATE TAXES	AVAIL. BED DAYS	806,222	20	61,377	37,960	1,806	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	\$	\$ 4,970	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center

0051086 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. Maint St.
 City / State / Zip Code Evanston, IL 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	Payroll Services	Direct		\$	\$		\$ 7,256	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				\$	\$		\$ 7,256	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center

0051086 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 Springfield Care Center

0051086 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 Springfield Care Center

0051086 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 Springfield Care Center

0051086 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 Springfield Care Center

0051086 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 Springfield Care Center

0051086

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							\$	\$			\$					
9																
10																
11																
12																
13																
14	TOTAL Working Capital															
	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.)

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>16,491</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>18,713</u>	2											
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>2,222</u>	3											
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>16,907</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.)		\$		5											
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6											
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>19,129</u>	7											
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2008	_____	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2012 \$ _____</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ _____</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2012 \$ _____	14	PLUS APPEAL COST FROM LINE 5 \$ _____	15	LESS REFUND FROM LINE 6 \$ _____	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____
FOR BHF USE ONLY															
13	FROM R. E. TAX STATEMENT FOR 2012 \$ _____														
14	PLUS APPEAL COST FROM LINE 5 \$ _____														
15	LESS REFUND FROM LINE 6 \$ _____														
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____														
	2009	_____	9												
	2010	<u>16,079</u>	10												
	2011	<u>16,491</u>	11												
	2012	<u>16,907</u>	12												
<u>2013 Accrual = 2012 Tax</u>															
<u>Allocated from 8131 N. Monticello = \$1,806</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 Springfield Care Center COUNTY Sangamon
 FACILITY IDPH LICENSE NUMBER 0051086
 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</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-35.0-157-019</u>	<u>Long Term Care Property</u>	\$ <u>16,906.66</u>	\$ <u>16,906.66</u>
2. <u>10-23-325-045-0000</u>	<u>Home Office Allocation</u>	\$ <u>70,066.20</u>	\$ <u>1,806.17</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>86,972.86</u></u>	\$ <u><u>18,712.83</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.

Facility Name & ID Number Springfield Care Center

0051086 Report Period Beginning:

01/01/13 Ending:

12/31/13

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Centralia Property, LLC</u>		<u>2011</u>	<u>\$ 183,518</u>	1
2	<u>Allocated from 8131 N. Monticello</u>			<u>2,619</u>	2
3	TOTALS			\$ 186,137	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	65		2011	1972	\$ 639,905	\$ 47,611	35	\$ 18,283	\$ (29,328)	\$ 60,943	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center

0051086

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	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			32,742	1,674	1,201	(473)	3,881	68
69				51,128		(51,128)		69
70			\$ 672,647	\$ 100,413		\$ 19,484	\$ (80,929)	\$ 64,824 70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Springfield Care Center

0051086

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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 672,647	\$ 100,413		\$ 19,484	\$ (80,929)	\$ 64,824	1
2	Bathroom Tile, Grout, Walls	2011	13,000		20	1,300	1,300	3,358	2
3	Water Heater	2011	6,082		20	1,216	1,216	3,041	3
4	3 Bathrooms & Hall Remodel, Walls, Tiles, Fixtures, Sinks, Toilet	2012	22,000		20	1,100	1,100	2,017	4
5	Hvac-Condensing Unit & Air Handlers	2012	20,500		20	1,025	1,025	1,794	5
6	New Asphalt	2012	12,836		20	856	856	1,569	6
7	50 Wall Units With Sleeves	2012	32,650		20	6,530	6,530	9,251	7
8	48 Window Units	2012	42,000		20	8,400	8,400	10,500	8
9	Phone System	2012	4,646		20	929	929	1,549	9
10	Patio & Patio Door Repairs	2012	4,750		20	238	238	475	10
11	Kitchen Remodel- Walls, Cabinets, & Countertop	2012	3,000		20	150	150	300	11
12	Sink, Disposer, & Redo Plumbing	2012	8,558		20	428	428	856	12
13	Water Heater	2012	4,200		20	210	210	420	13
14	Electric Breakers	2012	6,467		20	323	323	647	14
15	Fire Door	2013	2,828		20	141	141	141	15
16	Installation Of New Cat 5 Cables In All Work Stations	2013	4,800		20	240	240	240	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)		\$ 860,964	\$ 100,413		\$ 42,570	\$ (57,843)	\$ 100,981	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Springfield Care Center

0051086

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		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		\$ 860,964	\$ 100,413		\$ 42,570	\$ (57,843)	\$ 100,981	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
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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)		\$ 860,964	\$ 100,413		\$ 42,570	\$ (57,843)	\$ 100,981	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Springfield Care Center

0051086

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		\$ 860,964	\$ 100,413		\$ 42,570	\$ (57,843)	\$ 100,981		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)	\$ 860,964	\$ 100,413		\$ 42,570	\$ (57,843)	\$ 100,981		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Springfield Care Center

0051086

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		\$ 860,964	\$ 100,413		\$ 42,570	\$ (57,843)	\$ 100,981		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)	\$ 860,964	\$ 100,413		\$ 42,570	\$ (57,843)	\$ 100,981		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

Facility Name & ID Number Springfield Care Center

0051086

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	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		\$	\$		\$	\$	\$	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	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 8131 N. Monticello	2010	20,350	605	20	522	(83)	1,804	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from YAM Management	2010	969	97	20	97		317	9
10	Allocated from YAM Management	2012	612	41	20	41		62	10
11	Allocated from YAM Management	2013	109	6	20	6		6	11
12									12
13	Allocated from 8131 N. Monticello	2010	9,116	912	20	456	(456)	1,613	13
14	Allocated from 8131 N. Monticello	2013	1,586	13	20	79	66	79	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 Springfield Care Center

0051086

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	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		\$ 32,742	\$ 1,674		\$ 1,201	\$ (473)	\$ 3,881	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment 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	\$ 218,430	\$ 308	\$ 25,526	\$ 25,218	10	\$ 72,199	71
72	Current Year Purchases	14,163	68	2,378	2,310	10	2,378	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 232,593	\$ 376	\$ 27,904	\$ 27,528		\$ 74,576	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		2010 FORD E350 - Transfer from	2012	\$ 47,641	\$	\$ 9,115	\$ 9,115	5	\$ 14,219	76
77		Allocated from YAM Manageme	2009	1,001	213	213		5	503	77
78										78
79										79
80	TOTALS			\$ 48,642	\$ 213	\$ 9,328	\$ 9,115		\$ 14,722	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,328,336	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 101,002	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 79,802	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (21,200)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 190,279	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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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: \$ 4,488

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocated from YAM Consulting</u>		\$	\$ <u>1,088</u>	17
18	<u>Allocated from YAM Management</u>			<u>789</u>	18
19					19
20					20
21	TOTAL		\$	\$ <u>1,877</u>	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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. 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		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units	Cost			Units	Cost									
1	Licensed Occupational Therapist		hrs	\$		\$		\$									1
2	Licensed Speech and Language Development Therapist	N/A	hrs														2
3	Licensed Recreational Therapist		hrs														3
4	Licensed Physical Therapist		hrs														4
5	Physician Care		visits														5
6	Dental Care		visits														6
7	Work Related Program		hrs														7
8	Habilitation		hrs														8
9	Pharmacy		# of prescripts														9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs														10
11	Academic Education		hrs														11
12	Other (specify):																12
13	Other (specify): See Supplemental																13
14	TOTAL			\$		\$		\$		\$			\$				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 Springfield Care Center

0051086

Report 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	\$ 969	\$ 8,457	1
2	Cash-Patient Deposits	24,547	24,547	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	322,833	337,173	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	45,520	45,520	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	142,468	216,508	8
9	Other(specify): <u>See Attached Schedule</u>	17,459	17,459	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 553,796	\$ 649,664	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		183,518	13
14	Buildings, at Historical Cost		342,849	14
15	Leasehold Improvements, at Historical Cost	80,898	104,510	15
16	Equipment, at Historical Cost	204,070	386,365	16
17	Accumulated Depreciation (book methods)	(98,019)	(256,357)	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>	452,497	452,497	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 639,446	\$ 1,213,382	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,193,242	\$ 1,863,046	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,046,681	\$ 1,133,259	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,572	23,572	28
29	Short-Term Notes Payable	167,593	167,593	29
30	Accrued Salaries Payable	87,155	87,155	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,378	4,378	31
32	Accrued Real Estate Taxes(Sch.IX-B)		16,907	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	319,946	317,446	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,649,325	\$ 1,750,310	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	25,106	25,106	39
40	Mortgage Payable		845,530	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43			292,493	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 25,106	\$ 1,163,129	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,674,431	\$ 2,913,439	46
47	TOTAL EQUITY(page 18, line 24)	\$ (481,189)	\$ (1,050,393)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,193,242	\$ 1,863,046	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (298,078)	1
2	Restatements (describe):		2
3	Bad Debts	5,000	3
4	Rounding	5	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (293,073)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(184,783)	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	(3,333)	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)	\$ (188,116)	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)	\$ (481,189)	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	\$ 3,287,771	1
2	Discounts and Allowances for all Levels	(1,173,800)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,113,971	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,604	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,604	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	8	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,115,583	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	480,478	31
32	Health Care	838,754	32
33	General Administration	532,433	33
B. Capital Expense			
34	Ownership	251,733	34
C. Ancillary Expense			
35	Special Cost Centers	58,178	35
36	Provider Participation Fee	138,790	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,300,366	40
41	Income before Income Taxes (line 30 minus line 40)**	(184,783)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (184,783)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,990,334	44
45	Private Pay - Net Inpatient Revenue	121,610	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)	2,027	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,113,971	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Springfield Care Center**

0051086

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	2,024	2,163	\$ 85,419	\$ 39.49	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,601	5,136	119,540	23.27	3
4	Licensed Practical Nurses	8,383	9,014	172,361	19.12	4
5	CNAs & Orderlies	22,713	24,844	248,077	9.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,856	2,017	24,570	12.18	9
10	Activity Assistants	306	318	3,701	11.64	10
11	Social Service Workers	3,888	4,200	79,678	18.97	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,160	31,415	14.54	13
14	Head Cook	3,246	3,516	32,976	9.38	14
15	Cook Helpers/Assistants	5,491	5,846	48,292	8.26	15
16	Dishwashers					16
17	Maintenance Workers	2,032	2,072	34,927	16.86	17
18	Housekeepers	8,271	9,142	93,938	10.28	18
19	Laundry	33	33	295	8.94	19
20	Administrator	2,024	2,128	59,972	28.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,896	2,098	21,884	10.43	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,867	2,139	29,282	13.69	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	70,615	76,826	\$ 1,086,327 *	\$ 14.14	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	132	\$ 7,287	01-03	35
36	Medical Director	Monthly	13,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	251	18,900	10-03	38
39	Pharmacist Consultant	143	7,331	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	52	2,797	11-03	44
45	Social Service Consultant	68	3,287	12-03	45
46	Other(specify)				46
47	Psychiatric MD	Monthly	1,757	10-03	47
48					48
49	TOTAL (lines 35 - 48)	646	\$ 54,559		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												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center# 0051086

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. ICLTC \$3,094
- (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. \$ None Line N/A
- (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. \$ 138,790
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. \$ 22 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% 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? Yes
- 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.