

		FOR BHF USE					

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**2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)**

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

<p>I. IDPH License ID Number: <u>0050500</u></p> <p>Facility Name: <u>Concord Nursing & Rehab Center</u></p> <p>Address: <u>9401 South Ridgeland</u> <u>Oak Lawn</u> <u>60453</u> <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(708) 449-9090</u> Fax # <u>(708) 449-7070</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>11/23/10</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) <u>Cary C. Buxbaum, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>Cary C. Buxbaum, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center

0050500 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>134</u>	Skilled (SNF)	<u>134</u>	<u>48,910</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>134</u>	TOTALS	<u>134</u>	<u>48,910</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	3 Private Pay	4 Other	4 Total		
8	SNF	<u>34,754</u>	<u>3,059</u>	<u>7,423</u>	<u>45,236</u>	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>34,754</u>	<u>3,059</u>	<u>7,423</u>	<u>45,236</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.49%

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 1962

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 134 and days of care provided 4,992

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number Concord Nursing & Rehab Center # 0050500 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	209,032	16,181	26,524	251,737		251,737	(17,075)	234,662		1
2	Food Purchase		190,985		190,985		190,985	(129)	190,856		2
3	Housekeeping	153,076	20,459		173,535		173,535		173,535		3
4	Laundry	89,735	16,538		106,273		106,273		106,273		4
5	Heat and Other Utilities			114,145	114,145		114,145	1,083	115,228		5
6	Maintenance	42,823		101,196	144,019		144,019	3,630	147,649		6
7	Other (specify):*							1,262	1,262		7
8	TOTAL General Services	494,666	244,163	241,865	980,694		980,694	(11,229)	969,465		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	2,080,764	176,998	72,109	2,329,871		2,329,871	(53,708)	2,276,163		10
10a	Therapy	38,843			38,843		38,843		38,843		10a
11	Activities	76,161	3,764	959	80,884		80,884		80,884		11
12	Social Services	53,951		2,227	56,178		56,178		56,178		12
13	CNA Training										13
14	Program Transportation			240	240		240	2,729	2,969		14
15	Other (specify):*							5,298	5,298		15
16	TOTAL Health Care and Programs	2,249,719	180,762	99,535	2,530,016		2,530,016	(45,681)	2,484,335		16
	C. General Administration										
17	Administrative	73,647		51,696	125,343		125,343	32,663	158,006		17
18	Directors Fees										18
19	Professional Services			253,814	253,814	(185)	253,629	(161,254)	92,375		19
20	Dues, Fees, Subscriptions & Promotions			45,590	45,590		45,590	(16,980)	28,610		20
21	Clerical & General Office Expenses	149,305	2,972	209,291	361,568		361,568	(85,855)	275,713		21
22	Employee Benefits & Payroll Taxes			480,562	480,562		480,562		480,562		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,874	2,874		2,874	998	3,872		24
25	Other Admin. Staff Transportation			250	250		250	2,493	2,743		25
26	Insurance-Prop.Liab.Malpractice			110,258	110,258		110,258	1,506	111,764		26
27	Other (specify):*							18,972	18,972		27
28	TOTAL General Administration	222,952	2,972	1,154,335	1,380,259	(185)	1,380,074	(207,457)	1,172,617		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,967,337	427,897	1,495,735	4,890,969	(185)	4,890,784	(264,368)	4,626,416		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 Concord Nursing & Rehab Center #0050500 Report Period Beginning: 01/01/11 Ending: 12/31/11

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			53,333	53,333		53,333	(8,578)	44,755			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,207	12,207		12,207	(10,370)	1,837			32
33	Real Estate Taxes			219,616	219,616	185	219,801	2,069	221,870			33
34	Rent-Facility & Grounds			689,815	689,815		689,815	(14,000)	675,815			34
35	Rent-Equipment & Vehicles			5,700	5,700		5,700	6,153	11,853			35
36	Other (specify):*											36
37	TOTAL Ownership			980,671	980,671	185	980,856	(24,726)	956,130			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		183,066	527,881	710,947		710,947		710,947			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			73,365	73,365		73,365		73,365			42
43	Other (specify):*	12,919		368,883	381,802		381,802	(381,802)	0			43
44	TOTAL Special Cost Centers	12,919	183,066	970,129	1,166,114		1,166,114	(381,802)	784,312			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,980,256	610,963	3,446,535	7,037,754		7,037,754	(670,895)	6,366,859			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(7,892)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(13,479)	30		9
10	Interest and Other Investment Income	(14,366)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(129)	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	(13,449)	21		18
19	Entertainment	(5,811)	21		19
20	Contributions	(14,600)	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	(120,000)	21		24
25	Fund Raising, Advertising and Promotional	(2,951)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,065)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(428,363)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (623,105)		\$	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)	(47,790)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (47,790)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (670,895)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Concord Nursing & Rehab Center

ID# 0050500

Report Period Beginning: 01/01/11

Ending: 12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Additional R&M	\$ 9,681	6	1
2	Marketing	(20,099)	43	2
3	Bank Charges	(11,729)	21	3
4				4
5	Non-Allowable Fees	(348,090)	43	5
6	Non-Allowable Legal	(20,318)	19	6
7	Vending Commissions	(1,000)	21	7
8	Other Unclassified Income	(2,932)	21	8
9	Veteran Expense	(31,026)	10	9
10	Prior Period Professional Fees	(750)	19	10
11	2012 Professional Fees	(2,100)	19	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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42				42
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44				44
45				45
46				46
47				47
48				48
49	Total	(428,363)		49

Concord Nursing & Rehab Center

ID# 0050500

Report Period Beginning: 01/01/11

Ending: 12/31/11

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

		\$		
50				1
51				2
52				3
53				4
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STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				(17,075)								(17,075)	1
2	Food Purchase	(129)											(129)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,083									1,083	5
6	Maintenance	1,789		1,841									3,630	6
7	Other (specify):*			130	1,132								1,262	7
8	TOTAL General Services	1,660		3,054	(15,943)								(11,229)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(31,026)			(22,682)								(53,708)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation				2,729								2,729	14
15	Other (specify):*				5,298								5,298	15
16	TOTAL Health Care and Programs	(31,026)			(14,655)								(45,681)	16
	C. General Administration													
17	Administrative			25,403	7,260								32,663	17
18	Directors Fees													18
19	Professional Services	(23,168)		(130,051)	(8,403)	368							(161,254)	19
20	Fees, Subscriptions & Promotions	(17,551)		467	60	44							(16,980)	20
21	Clerical & General Office Expenses	(156,986)		63,429	7,631	71							(85,855)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			723	275								998	24
25	Other Admin. Staff Transportation			2,101	392								2,493	25
26	Insurance-Prop.Liab.Malpractice			1,506									1,506	26
27	Other (specify):*			16,814	2,158								18,972	27
28	TOTAL General Administration	(197,705)		(19,608)	9,373	483							(207,457)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(227,072)		(16,554)	(21,225)	483							(264,368)	29

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(13,479)		1,183	48	3,670							(8,578)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(14,366)		72		3,924							(10,370)	32
33	Real Estate Taxes			3,306		(1,237)							2,069	33
34	Rent-Facility & Grounds			(2,891)		(11,109)							(14,000)	34
35	Rent-Equipment & Vehicles			1,744	4,409								6,153	35
36	Other (specify):*													36
37	TOTAL Ownership	(27,845)		3,414	4,457	(4,752)							(24,726)	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):*	(368,189)			(13,613)								(381,802)	43
44	TOTAL Special Cost Centers	(368,189)			(13,613)								(381,802)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(623,105)		(13,140)	(30,381)	(4,269)							(670,895)	45

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/11

Ending:

12/31/11

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%	\$ 1,083	\$	1,083	15
16	V	6 REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	1,841		1,841	16
17	V	7 EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	130		130	17
18	V	17 ADMINISTRATIVE		YAM MANAGEMENT, LLC	100.00%	25,403		25,403	18
19	V	19 PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	1,897		1,897	19
20	V	20 FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	467		467	20
21	V	21 CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	63,429		63,429	21
22	V	24 SEMINARS		YAM MANAGEMENT, LLC	100.00%	723		723	22
23	V	25 AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	2,101		2,101	23
24	V	26 INSURANCE		YAM MANAGEMENT, LLC	100.00%	1,506		1,506	24
25	V	27 EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	16,814		16,814	25
26	V	30 DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	1,183		1,183	26
27	V	32 INTEREST		YAM MANAGEMENT, LLC	100.00%	72		72	27
28	V	33 REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%	3,306		3,306	28
29	V	34 RENT		YAM MANAGEMENT, LLC	100.00%	11,109		11,109	29
30	V	35 AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	1,288		1,288	30
31	V	35 EQUIPMENT RENTAL		YAM MANAGEMENT, LLC	100.00%	456		456	31
32	V			YAM MANAGEMENT, LLC	100.00%				32
33	V								33
34	V	19 OTHER PROFESSIONAL FEES	2,000	YAM MANAGEMENT, LLC	100.00%			(2,000)	34
35	V	19 BOOKKEEPING FEES	93,948	YAM MANAGEMENT, LLC	100.00%			(93,948)	35
36	V	19 ACCOUNTING	36,000	YAM MANAGEMENT, LLC	100.00%			(36,000)	36
37	V	34 RENT	14,000	YAM MANAGEMENT, LLC	100.00%			(14,000)	37
38	V								38
39	Total		\$ 145,948			\$ 132,808	\$ *	(13,140)	39

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

Facility Name & ID Number Concord Nursing & Rehab Center# 0050500Report Period Beginning: 01/01/11Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	<u>1</u> <u>DIETARY</u>	\$	<u>YAM CONSULTING, LLC</u>	100.00%	\$ 9,449	\$ 9,449
16	V	<u>7</u> <u>EMP. BEN. GEN. SERV.</u>		<u>YAM CONSULTING, LLC</u>	100.00%	1,132	1,132
17	V	<u>10</u> <u>NURSING SALARY</u>		<u>YAM CONSULTING, LLC</u>	100.00%	42,554	42,554
18	V	<u>14</u> <u>PROGRAM TRANSPORTATION</u>		<u>YAM CONSULTING, LLC</u>	100.00%	2,729	2,729
19	V	<u>15</u> <u>EMP. BEN. HEALTHCARE</u>		<u>YAM CONSULTING, LLC</u>	100.00%	5,298	5,298
20	V	<u>17</u> <u>ADMINISTRATIVE</u>		<u>YAM CONSULTING, LLC</u>	100.00%	13,956	13,956
21	V	<u>19</u> <u>PROFESSIONAL FEES</u>		<u>YAM CONSULTING, LLC</u>	100.00%	3,701	3,701
22	V	<u>20</u> <u>FEES, SUBSCRIPTIONS</u>		<u>YAM CONSULTING, LLC</u>	100.00%	60	60
23	V	<u>21</u> <u>CLERICAL & GENERAL</u>		<u>YAM CONSULTING, LLC</u>	100.00%	7,631	7,631
24	V	<u>24</u> <u>SEMINARS</u>		<u>YAM CONSULTING, LLC</u>	100.00%	275	275
25	V	<u>25</u> <u>AUTO AND TRAVEL</u>		<u>YAM CONSULTING, LLC</u>	100.00%	392	392
26	V	<u>27</u> <u>EMP. BEN.-GEN. ADMIN.</u>		<u>YAM CONSULTING, LLC</u>	100.00%	2,158	2,158
27	V	<u>30</u> <u>DEPRECIATION</u>		<u>YAM CONSULTING, LLC</u>	100.00%	48	48
28	V	<u>35</u> <u>AUTO RENTAL</u>		<u>YAM CONSULTING, LLC</u>	100.00%	4,409	4,409
29	V						
30	V						
31	V						
32	V						
33	V	<u>1</u> <u>DIETICIAN CONSULTING</u>	26,524	<u>YAM CONSULTING, LLC</u>	100.00%		(26,524)
34	V	<u>10</u> <u>NURSE CONSULTING</u>	65,236	<u>YAM CONSULTING, LLC</u>	100.00%		(65,236)
35	V	<u>17</u> <u>DIR. OF OPERATIONS CONSULT</u>	6,696	<u>YAM CONSULTING, LLC</u>	100.00%		(6,696)
36	V	<u>19</u> <u>DATA PROCESSING FEES</u>	12,104	<u>YAM CONSULTING, LLC</u>	100.00%		(12,104)
37	V	<u>43</u> <u>MARKETING</u>	13,613	<u>YAM CONSULTING, LLC</u>	100.00%		(13,613)
38	V						
39	Total		\$ 124,173			\$ 93,792	\$ * (30,381)

* 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%	\$ 368	\$	368	15
16	V	20 DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		44		44	16
17	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC		71		71	17
18	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC		3,670		3,670	18
19	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC		3,924		3,924	19
20	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		2,069		2,069	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34 RENT	11,109	8131 N. MONTICELLO, LLC				(11,109)	26
27	V	33 REAL ESTATE TAXES	3,306					(3,306)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 14,415			\$ 10,146	\$ *	(4,269)	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/11

Ending:

12/31/11

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	1219 Limited Partnership	2.000%	BERKSHIRE NURSING & REHAB CENTER,LLC	FOREST PARK	YAM MANAGEMENT	SKOKIE	MANAGEMENT CO.	1
2	257 Limited Partnership	4.000%	DOLTON NURSING & REHAB,LLC	DOLTON	YAM CONSULTING	SKOKIE	CONSULTING CO.	2
3	42170 Limited Partnership	2.000%	EVANSTON NURSING & REHAB CENTER, LLC	EVANSTON	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDIN	3
4	Concord SNF Equity Partners, LLC	45.000%	EXCEPTIONAL CARE, LLC	BURBANK				4
5	David Berkowitz	23.500%	FAIRVIEW CARE CENTER OF JOLIET,LLC	JOLIET				5
6	Jay Meystel Trust	12.500%	HIGHLAND PARK NURSING AND REHAB CENTER, LLC	HIGHWOOD				6
7	Yosef Meystel	11.000%	INTERNATIONAL NURSING & REHAB CENTER,LLC	CHICAGO				7
8			JACKSONVILLE CARE CENTER	JACKSONVILLE				8
9			LITCHFIELD CARE CENTER,LLC	LITCHFIELD				9
10			NORTH CHURCH NURSING & REHAB,LLC	JACKSONVILLE				10
11			PLAZA NURSING AND REHAB CENTER,LLC	MIDLOTHIAN				11
12			PLUM GROVE NURSING AND REHAB,LLC	PALATINE				12
13			RIVIERA CARE CENTER,LLC	CHICAGO HEIGHTS				13
14			ROCKFORD NUR. & REHAB	ROCKFORD				14
15			SPRINGFIELD CARE CENTER,LLC	SPRINGFIELD				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

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

Facility Name & ID Number Concord Nursing & Rehab Center # 0050500 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Berkowitz	Owner	Administrative	23.50%	See Attached	2.8	7.00%	Mngmt Fees	\$ 28,000	17-3	1
2	Yosef Meystel	Owner	Administrative	11.00%	See Attached	2.8	7.00%	Mngmt Fees	17,000	17-3	2
3	Joel Meystel	Relative	Administrative	0.00%	See Attached	1.4	7.00%	Alloc. Salary	1,640	17-7	3
4	Jay Meystel	Relative	Administrative	0.00%	See Attached	1.4	3.50%	Alloc. Salary	4,308	17-7	4
5											5
6											6
7	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated										7
8	to be considered allowable by the IL Dept of HFS.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 50,948		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	AVAIL. BED DAYS	686,836	17	\$ 15,204	\$ 48,910	\$ 1,083	1	
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	686,836	17	25,846	8,238	48,910	1,841	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	686,836	17	1,829		48,910	130	3
4	17	ADMINISTRATIVE	AVAIL. BED DAYS	686,836	17	356,736	356,736	48,910	25,403	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	26,635		48,910	1,897	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	6,564		48,910	467	6
7	21	CLERICAL & GENERAL	AVAIL. BED DAYS	686,836	17	890,719	835,933	48,910	63,429	7
8	24	SEMINARS	AVAIL. BED DAYS	686,836	17	10,148		48,910	723	8
9	25	AUTO AND TRAVEL	AVAIL. BED DAYS	686,836	17	29,510		48,910	2,101	9
10	26	INSURANCE	AVAIL. BED DAYS	686,836	17	21,145		48,910	1,506	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	686,836	17	236,117		48,910	16,814	11
12	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	16,611		48,910	1,183	12
13	32	INTEREST	AVAIL. BED DAYS	686,836	17	1,006		48,910	72	13
14	33	REAL ESTATE TAX	AVAIL. BED DAYS	686,836	17	46,424		48,910	3,306	14
15	34	RENT	AVAIL. BED DAYS	686,836	17	156,000		48,910	11,109	15
16	35	AUTO RENTAL	AVAIL. BED DAYS	686,836	17	18,091		48,910	1,288	16
17	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	686,836	17	6,400		48,910	456	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,864,985	\$ 1,200,907	\$ 132,808		25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY	AVAIL. BED DAYS	686,836	17	\$ 132,684	\$ 123,698	48,910	\$ 9,449	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	686,836	17	15,896		48,910	1,132	2
3	10	NURSING SALARY	AVAIL. BED DAYS	686,836	17	597,577	597,577	48,910	42,554	3
4	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	686,836	17	38,325		48,910	2,729	4
5	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	686,836	17	74,394		48,910	5,298	5
6	17	ADMINISTRATIVE	AVAIL. BED DAYS	686,836	17	195,987	195,987	48,910	13,956	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	51,975		48,910	3,701	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	849		48,910	60	8
9	21	CLERICAL & GENERAL	AVAIL. BED DAYS	686,836	17	107,160	91,547	48,910	7,631	9
10	24	SEMINARS	AVAIL. BED DAYS	686,836	17	3,858		48,910	275	10
11	25	AUTO AND TRAVEL	AVAIL. BED DAYS	686,836	17	5,508		48,910	392	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	686,836	17	30,309		48,910	2,158	12
13	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	673		48,910	48	13
14	35	AUTO RENTAL	AVAIL. BED DAYS	686,836	17	61,921		48,910	4,409	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,317,116	\$ 1,008,809		\$ 93,792	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	\$ 5,168	\$ 48,910	\$ 368	1
2	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	624	48,910	44	2
3	21	OFFICE EXPENSE	AVAIL. BED DAYS	686,836	17	1,000	48,910	71	3
4	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	51,542	48,910	3,670	4
5	32	INTEREST EXPENSE	AVAIL. BED DAYS	686,836	17	55,103	48,910	3,924	5
6	33	REAL ESTATE TAXES	AVAIL. BED DAYS	686,836	17	29,058	48,910	2,069	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 142,495	\$	\$ 10,146	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/11

Ending:

12/31/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1					\$	\$			\$	1									
2										2									
3										3									
4										4									
5	See Supplemental Schedule																		
Working Capital																			
6	Private Bank	X	Line of Credit			794,000			10,386	6									
7	Insurance Financing	X							1,821	7									
8	See Supplemental Schedule																		
9	TOTAL Facility Related				\$	\$ 794,000			\$ 12,207	9									
B. Non-Facility Related*																			
10	Interest Income	X							(14,366)	10									
11	Allocated from 8131 N. Monticello																		
12	Allocated from YAM Management																		
13	See Supplemental Schedule																		
14	TOTAL Non-Facility Related				\$	\$			\$ (10,370)	14									
15	TOTALS (line 9+line14)				\$	\$ 794,000			\$ 1,837	15									

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Nursing & Rehab Center # 0050500 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

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

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

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	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.)		\$	221,685		2
3. Under or (over) accrual (line 2 minus line 1).		\$	221,685		3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			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.)		\$	185		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.		\$	221,870		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006	154,149	8	FOR BHF USE ONLY	
	2007	156,982	9	13	FROM R. E. TAX STATEMENT FOR 2010 \$ 13
	2008	290,460	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2009	220,150	11	15	LESS REFUND FROM LINE 6 \$ 15
	2010	219,616	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
Allocated from 8131 N. Monticello - \$2,269					

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Concord Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050500

CONTACT PERSON REGARDING THIS REPORT 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 2010 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 2010.

(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>24-05-302-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>219,616.00</u>	\$ <u>219,616.00</u>
2. <u>10-23-325-045-0000</u>	<u>Home Office Allocation</u>	\$ <u>35,987.49</u>	\$ <u>2,244.88</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>255,603.49</u>	\$ <u>221,860.88</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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.**

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Concord Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050500

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

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

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

0050500

Report Period Beginning:

01/01/11

Ending:

12/31/11

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2	<u>Allocated from 8131 N. Monticello</u>			<u>6,338</u>	2
3	TOTALS			\$ <u>6,338</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68		73,649	3,905		2,601	(1,304)	3,837	68
69			33,902			(33,902)		69
70		\$ 73,649	\$ 37,807		\$ 2,601	\$ (35,206)	\$ 3,837	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 73,649	\$ 37,807		\$ 2,601	\$ (35,206)	\$ 3,837	1
2	Cable/Cameras/Labor	2009	11,266		20	563	563	1,455	2
3	Wire Building	2009	9,950		20	498	498	1,327	3
4	Flooring	2009	59,050		20	2,953	2,953	7,873	4
5	Nurse Station	2009	18,000		20	900	900	2,325	5
6	Boiler- Gas Valve	2010	2,899		20	290	290	580	6
7	Ramp Rails	2010	8,750		20	875	875	1,458	7
8	Rooftop Hvac	2010	7,900		20	790	790	1,251	8
9	Ceiling, Lighting, Wallcovering - Corridors & Nurses Station	2010	150,939		20	15,094	15,094	23,899	9
10	Missing Shingles	2010	2,950		20	295	295	393	10
11	Ejector Pump	2010	4,729		20	946	946	1,576	11
12	Hardwood Floor	2011	3,900		20	146	146	146	12
13	Plumbing	2011	5,200		20	130	130	130	13
14	Corridor Sinage	2011	6,193		20	103	103	103	14
15	Boiler	2011	24,900		20	415	415	415	15
16	Hardwood Floor	2011	3,300		20	55	55	55	16
17	Tuck Pointing	2011	4,700		20	78	78	78	17
18	Lobby-Repair Walls,New Wallcovering,Paint Ceiling	2011	17,401		20	870	870	870	18
19	Parlor Area-Newa Wallcovering	2011	3,467		20	173	173	173	19
20	Dining Room-Install New Oak Plywood Over Beams	2011	14,186		20	709	709	709	20
21	Vestibule-New Flooring, Wallcovering And Lighting	2011	7,144		20	357	357	357	21
22	Lobby-New Lighting	2011	3,133		20	157	157	157	22
23	Dinning Rm-New Wallcovering, Lighting, Replace Ceiling Tile	2011	37,703		20	1,885	1,885	1,885	23
24	Therapy Rm-New Wallcovering, Lighting & Custom Built In Cabi	2011	37,421		20	1,871	1,871	1,871	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)		\$ 518,731	\$ 37,807		\$ 32,754	\$ (5,053)	\$ 52,925	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		\$ 518,731	\$ 37,807		\$ 32,754	\$ (5,053)	\$ 52,925	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)	\$ 518,731	\$ 37,807		\$ 32,754	\$ (5,053)	\$ 52,925	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		\$ 518,731	\$ 37,807		\$ 32,754	\$ (5,053)	\$ 52,925	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)	\$ 518,731	\$ 37,807		\$ 32,754	\$ (5,053)	\$ 52,925	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		\$ 518,731	\$ 37,807		\$ 32,754	\$ (5,053)	\$ 52,925
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 518,731	\$ 37,807		\$ 32,754	\$ (5,053)	\$ 52,925

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 8131 N. Monticello	2010	49,244	1,464	39	1,263	(201)	1,841	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from YAM Management	2010	2,346	235	20	235		299	9
10	Allocated from 8131 N. Monticello	2010	22,059	2,206	20	1,103	(1,103)	1,697	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1								1	
2								2	
3								3	
4								4	
5								5	
6								6	
7								7	
8								8	
9								9	
10								10	
11								11	
12								12	
13								13	
14								14	
15								15	
16								16	
17								17	
18								18	
19								19	
20								20	
21								21	
22								22	
23								23	
24								24	
25								25	
26								26	
27								27	
28								28	
29								29	
30								30	
31								31	
32								32	
33								33	
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 73,649	\$ 3,905		\$ 2,601	\$ (1,304)	\$ 3,837	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 63,937	\$ 776	\$ 8,745	\$ 7,969	10	\$ 18,038	71
72	Current Year Purchases	30,559	19,440	3,045	(16,395)	10	3,045	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 94,496	\$ 20,216	\$ 11,790	\$ (8,426)		\$ 21,083	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from YAM Manager	2011	\$ 1,915	\$ 212	\$ 212	\$	5	\$ 72	76
77										77
78										78
79										79
80	TOTALS			\$ 1,915	\$ 212	\$ 212	\$		\$ 72	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)	\$ 621,480	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 58,235	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 44,756	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (13,479)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 74,080	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Concord Healthcare Properties

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions				<u>675,586</u>			4
5	<u>Public Storage Rental</u>				<u>229</u>			5
6								6
7	TOTAL				\$ <u>675,815</u>			7

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 456 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>Facility</u>	<u>Toyota</u>	\$	\$ <u>5,700</u>	17
18	<u>Allocated from YAM Consulting</u>			<u>4,409</u>	18
19	<u>Allocated from YAM Management</u>			<u>1,288</u>	19
20					20
21	TOTAL		\$	\$ <u>11,397</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending 2/18/19

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

Fiscal Year Ending Annual Rent

12. 12/31/2012 \$ 699,862

13. 12/31/2013 \$ 724,128

14. 12/31/2014 \$ 748,402

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 227,265	\$		\$ 227,265	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			85,671			85,671	2
3	Licensed Recreational Therapist	39 - 03	hrs			1,913			1,913	3
4	Licensed Physical Therapist	39 - 03	hrs			213,032			213,032	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				174,124		174,124	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>						8,942		8,942	13
14	TOTAL			\$		\$ 527,881	\$ 183,066		\$ 710,947	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center# 0050500Report Period Beginning: 01/01/11Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 8,140	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,471,127		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	58,128		6
7	Other Prepaid Expenses	99,409		7
8	Accounts Receivable (owners or related parties)	500,000		8
9	Other(specify): <u>See Attached Schedule</u>	273,215		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,410,019	\$	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	478,216		15
16	Equipment, at Historical Cost	102,172		16
17	Accumulated Depreciation (book methods)	(106,484)		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>	338,900		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 812,804	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,222,823	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 515,582	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,671		28
29	Short-Term Notes Payable	794,000		29
30	Accrued Salaries Payable	211,776		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,293		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	3,440		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	304,735		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,863,497	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,863,497	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,359,326	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,222,823	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,491,978	1
2	Restatements (describe):		2
3	Adjusting Journal Entries	4,017	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,495,995	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,656,297	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	(792,966)	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)	\$ 863,331	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)	\$ 2,359,326	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center# 0050500Report Period Beginning: 01/01/11Ending: 12/31/11

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,886,505	1
2	Discounts and Allowances for all Levels	128,698	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,015,203	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,461,669	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,461,669	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	158,709	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,051	19
20	Radiology and X-Ray	8,546	20
21	Other Medical Services	14,041	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 198,347	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	14,366	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 14,366	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	4,466	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,466	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,694,051	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	980,694	31
32	Health Care	2,530,016	32
33	General Administration	1,380,259	33
B. Capital Expense			
34	Ownership	980,671	34
C. Ancillary Expense			
35	Special Cost Centers	1,092,749	35
36	Provider Participation Fee	73,365	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,037,754	40
41	Income before Income Taxes (line 30 minus line 40)**	1,656,297	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,656,297	43

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

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

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

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

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

0050500

Report Period Beginning:

01/01/11

Ending:

12/31/11

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,974	2,062	\$ 84,313	\$ 40.89	1
2	Assistant Director of Nursing	1,901	2,094	72,469	34.61	2
3	Registered Nurses	8,221	8,780	189,857	21.62	3
4	Licensed Practical Nurses	31,546	33,442	846,922	25.33	4
5	CNAs & Orderlies	67,640	73,352	806,138	10.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,449	3,651	38,843	10.64	8
9	Activity Director	1,873	2,086	26,553	12.73	9
10	Activity Assistants	5,662	5,820	49,608	8.52	10
11	Social Service Workers	3,447	3,738	53,951	14.43	11
12	Dietician					12
13	Food Service Supervisor	1,443	1,743	33,607	19.28	13
14	Head Cook	3,708	3,999	41,451	10.37	14
15	Cook Helpers/Assistants	13,328	14,213	133,974	9.43	15
16	Dishwashers					16
17	Maintenance Workers	2,431	2,774	42,823	15.44	17
18	Housekeepers	13,326	14,440	153,076	10.60	18
19	Laundry	7,479	8,474	89,735	10.59	19
20	Administrator	1,939	2,086	73,647	35.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,701	10,704	149,305	13.95	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	1,879	2,027	81,065	39.99	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	918	966	12,919	13.37	33
34	TOTAL (lines 1 - 33)	181,865	196,451	\$ 2,980,256 *	\$ 15.17	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	442	\$ 26,524	01-03	35
36	Medical Director	Monthly	24,000	09-03	36
37	Medical Records Consultant	6	300	10-03	37
38	Nurse Consultant	1,305	65,236	10-03	38
39	Pharmacist Consultant	Monthly	6,573	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	32	959	11-03	44
45	Social Service Consultant	45	2,227	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,829	\$ 125,819		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

Facility Name & ID Number Concord Nursing & Rehab Center

0050500

Report Period Beginning: 01/01/11

Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount			
Michael Nudell	Administrator	0.00%	\$ 73,647	Workers' Compensation Insurance	\$ 117,612	IDPH License Fee	\$			
				Unemployment Compensation Insurance	78,334	Advertising: Employee Recruitment	1,523			
				FICA Taxes	227,748	Health Care Worker Background Check (Indicate # of checks performed)				
				Employee Health Insurance	49,250	Patient Background Checks	412 4,117			
				Employee Meals	237	Dues & Subscriptions	17,328			
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Permits	5,071			
				Employee Benefits-other	6,880	Allocated from YAM Consulting	60			
				Employee Welfare	501	Allocated from YAM Management	467			
						See Supplemental Schedule	44			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 73,647	TOTAL (agree to Schedule V, line 22, col.8)			\$ 480,562	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 28,610
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description	Amount		
Yosef Meystel - Management Fees			\$ 17,000				Out-of-State Travel	\$		
David Berkowitz - Management Fees			28,000							
Administrative Consulting- YAM			6,696				In-State Travel			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 51,696	TOTAL				Seminar Expense	2,874	
C. Professional Services										
Vendor/Payee	Type		Amount							
YAM Management	Bookkeeping/Accounting		\$ 129,948				Allocated from YAM Consulting		275	
YAM Consulting	Data Processing		12,104				Allocated from YAM Management		723	
See Attached	Legal		22,417				Entertainment Expense (agree to Sch. V, line 24, col. 8)			
FR&R	Accounting		25,900				TOTAL		\$ 3,872	
E-Health Data Solutions	MDS Software		4,049							
Personnel Planners, Inc	Unemployment Consulting		2,692							
Global Detective	Private Investigator Services		4,050							
Prospect Resources, Inc	Natural Gas Procurement		1,300							
National Datacare	Data Processing		2,343							
MDI Achieve	Data Processing		13,265							
IIT/Source Tech	Data Processing		605							
See Supplemental Schedule			35,142							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 253,814							

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Nursing & Rehab Center# 0050500Report Period Beginning: 01/01/11Ending: 12/31/11**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC- \$14,271
- (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/S
- (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. \$ 33,125 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? X YES NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 73,365
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 237 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% line 14
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT