

Facility Name & ID Number Litchfield Care Center

0051102 Report Period Beginning: 01/01/12 Ending: 12/31/12

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	65	Intermediate (ICF)	65	23,790	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	65	TOTALS	65	23,790	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	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	22,091	742		22,833	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,091	742		22,833	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.98%

D. How many bed-hold days during this year were paid by the Department? 81 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 9/01/2010

J. Was the facility purchased or leased after January 1, 1978?
YES Date 9/01/2010 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

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

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

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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	121,655	10,553	5,382	137,590		137,590	4,452	142,042		1
2	Food Purchase		106,746		106,746		106,746	(35)	106,711		2
3	Housekeeping	61,039	10,003		71,042		71,042		71,042		3
4	Laundry	35,014	10,600		45,614		45,614		45,614		4
5	Heat and Other Utilities			48,213	48,213		48,213	131	48,344		5
6	Maintenance	56,838	8,848	19,010	84,696		84,696	4,079	88,775		6
7	Other (specify):*							822	822		7
8	TOTAL General Services	274,546	146,750	72,605	493,901		493,901	9,449	503,350		8
	B. Health Care and Programs										
9	Medical Director			6,500	6,500		6,500		6,500		9
10	Nursing and Medical Records	578,044	21,358	24,133	623,535		623,535	7,720	631,255		10
10a	Therapy										10a
11	Activities	34,525	2,940	2,965	40,430		40,430		40,430		11
12	Social Services	77,236		2,965	80,201		80,201		80,201		12
13	CNA Training										13
14	Program Transportation							928	928		14
15	Other (specify):*							2,808	2,808		15
16	TOTAL Health Care and Programs	689,805	24,298	36,563	750,666		750,666	11,456	762,122		16
	C. General Administration										
17	Administrative	88,475		35,596	124,071		124,071	(4,810)	119,261		17
18	Directors Fees										18
19	Professional Services			109,540	109,540		109,540	(75,142)	34,398		19
20	Dues, Fees, Subscriptions & Promotions			12,671	12,671		12,671	(5,437)	7,234		20
21	Clerical & General Office Expenses	51,660		28,285	79,945		79,945	24,535	104,480		21
22	Employee Benefits & Payroll Taxes			179,890	179,890		179,890		179,890		22
23	Inservice Training & Education										23
24	Travel and Seminar			632	632		632	725	1,357		24
25	Other Admin. Staff Transportation			12,323	12,323		12,323	797	13,120		25
26	Insurance-Prop.Liab.Malpractice			26,536	26,536		26,536	798	27,334		26
27	Other (specify):*							11,054	11,054		27
28	TOTAL General Administration	140,135		405,473	545,608		545,608	(47,480)	498,128		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,104,486	171,048	514,641	1,790,175		1,790,175	(26,574)	1,763,601		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

Litchfield Care Center

#0051102

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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			37,054	37,054		37,054	30,587	67,641			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,349	24,349		24,349	57,690	82,039			32
33	Real Estate Taxes							24,963	24,963			33
34	Rent-Facility & Grounds			176,988	176,988		176,988	(176,988)				34
35	Rent-Equipment & Vehicles			6,191	6,191		6,191	2,303	8,494			35
36	Other (specify):*			1,031	1,031		1,031	(1,031)	0			36
37	TOTAL Ownership			245,613	245,613		245,613	(62,476)	183,137			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,503		1,503		1,503		1,503			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			277,569	277,569		277,569		277,569			42
43	Other (specify):*			58,209	58,209		58,209	(58,209)				43
44	TOTAL Special Cost Centers		1,503	335,778	337,281		337,281	(58,209)	279,072			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,104,486	172,551	1,096,032	2,373,069		2,373,069	(147,259)	2,225,810			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center

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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	(328)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(17,349)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(35)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(25)	21		18
19	Entertainment	(925)	21		19
20	Contributions	(3,000)	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	(5,763)	21		24
25	Fund Raising, Advertising and Promotional	(519)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(67,984)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (95,928)		\$	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)	(51,331)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (51,331)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (147,259)		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

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Charges	\$ (4,486)	21	1
2	Amortization	(1,031)	36	2
3	Additional R&M	2,155	06	3
4	COPE Dues	(2,894)	20	4
5	Bank Charges - Bldg. Co	(77)	21	5
6	License & Fees Bldg. Co	(250)	20	6
7	Professional fees - Bldg Co.	(2,500)	19	7
8	Non-allowable Fees	(57,690)	43	8
9	Non-allowable Legal Fees	(1,212)	19	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(67,984)		49

Litchfield Care Center

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Litchfield Care Center# 0051102

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				4,452								4,452	1
2	Food Purchase	(35)											(35)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(328)		459									131	5
6	Maintenance	2,155		883	1,041								4,079	6
7	Other (specify):*			67	755								822	7
8	TOTAL General Services	1,792		1,409	6,248								9,449	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				7,720								7,720	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation				928								928	14
15	Other (specify):*				2,808								2,808	15
16	TOTAL Health Care and Programs				11,456								11,456	16
	C. General Administration													
17	Administrative			12,335	(17,145)								(4,810)	17
18	Directors Fees													18
19	Professional Services	(3,712)	(1,146)	(70,022)	(335)	73							(75,142)	19
20	Fees, Subscriptions & Promotions	(6,144)	250	393	42	22							(5,437)	20
21	Clerical & General Office Expenses	(11,276)	77	32,207	3,527								24,535	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			161	564								725	24
25	Other Admin. Staff Transportation			538	259								797	25
26	Insurance-Prop.Liab.Malpractice			798									798	26
27	Other (specify):*			8,526	2,528								11,054	27
28	TOTAL General Administration	(21,132)	(819)	(15,064)	(10,560)	95							(47,480)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(19,339)	(819)	(13,655)	7,144	95							(26,574)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Litchfield Care Center# 0051102

Report Period Beginning:

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Ending:

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(17,349)	45,504	674		1,758							30,587	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		55,086	859		1,745							57,690	32
33	Real Estate Taxes		22,989			1,974							24,963	33
34	Rent-Facility & Grounds		(164,988)	(4,905)		(7,095)							(176,988)	34
35	Rent-Equipment & Vehicles			932	1,371								2,303	35
36	Other (specify):*	(1,031)											(1,031)	36
37	TOTAL Ownership	(18,380)	(41,409)	(2,440)	1,371	(1,618)							(62,476)	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):*	(58,209)											(58,209)	43
44	TOTAL Special Cost Centers	(58,209)											(58,209)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(95,928)	(42,228)	(16,095)	8,515	(1,523)							(147,259)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		
				Centralia Property, LLC		Building Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 164,988	Centralia Property, LLC	100.00%	\$	(164,988)	1
2	V	21 Bank Charges		Centralia Property, LLC		77	77	2
3	V	30 Depreciation Expense		Centralia Property, LLC		45,504	45,504	3
4	V	20 License & Fees		Centralia Property, LLC		250	250	4
5	V	19 Professional Fees		Centralia Property, LLC		2,500	2,500	5
6	V	33 Real Estate Taxes		Centralia Property, LLC		22,989	22,989	6
7	V	32 Interst Expense		Centralia Property, LLC		55,086	55,086	7
8	V	19 Accounting Fees	3,646	Centralia Property, LLC			(3,646)	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 168,634			\$ 126,406	\$ * (42,228)	14

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

Facility Name & ID Number

Litchfield Care Center

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Report Period Beginning:

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Ending:

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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%	\$ 459	\$	459	15
16	V	6 REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	883		883	16
17	V	7 EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	67		67	17
18	V	17 ADMINISTRATIVE		YAM MANAGEMENT, LLC	100.00%	12,335		12,335	18
19	V	19 PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	759		759	19
20	V	20 FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	393		393	20
21	V	21 CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	32,207		32,207	21
22	V	24 SEMINARS		YAM MANAGEMENT, LLC	100.00%	161		161	22
23	V	25 AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	538		538	23
24	V	26 INSURANCE		YAM MANAGEMENT, LLC	100.00%	798		798	24
25	V	27 EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	8,526		8,526	25
26	V	30 DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	674		674	26
27	V	32 INTEREST		YAM MANAGEMENT, LLC	100.00%	859		859	27
28	V	33 REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%				28
29	V	34 RENT		YAM MANAGEMENT, LLC	100.00%	7,095		7,095	29
30	V	35 AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	809		809	30
31	V	35 EQUIPMENT RENTAL		YAM MANAGEMENT, LLC	100.00%	123		123	31
32	V	0		YAM MANAGEMENT, LLC	100.00%				32
33	V								33
34	V								34
35	V	19 BOOKKEEPING FEES	58,508	YAM MANAGEMENT, LLC	100.00%			(58,508)	35
36	V	19 ACCOUNTING	12,273	YAM MANAGEMENT, LLC	100.00%			(12,273)	36
37	V	34 RENT	12,000	YAM MANAGEMENT, LLC	100.00%			(12,000)	37
38	V								38
39	Total		\$ 82,781			\$ 66,686	\$ *	(16,095)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1	DIETARY		100.00%	\$ 4,452	\$	4,452	15
16	V	7	EMP. BEN. GEN. SERV.		100.00%	755		755	16
17	V	10	NURSING SALARY		100.00%	21,214		21,214	17
18	V	14	PROGRAM TRANSPORTATION		100.00%	928		928	18
19	V	15	EMP. BEN. HEALTHCARE		100.00%	2,808		2,808	19
20	V	17	ADMINISTRATIVE		100.00%	11,451		11,451	20
21	V	19	PROFESSIONAL FEES		100.00%	191		191	21
22	V	20	FEES, SUBSCRIPTIONS		100.00%	42		42	22
23	V	21	CLERICAL & GENERAL		100.00%	3,527		3,527	23
24	V	24	SEMINARS		100.00%	564		564	24
25	V	25	AUTO AND TRAVEL		100.00%	259		259	25
26	V	27	EMP. BEN.-GEN. ADMIN.		100.00%	2,528		2,528	26
27	V	30	DEPRECIATION		100.00%				27
28	V	35	AUTO RENTAL		100.00%	1,371		1,371	28
29	V	6	REPAIRS AND MAINTENANCE SALARY		100.00%	1,041		1,041	29
30	V								30
31	V								31
32	V								32
33	V	10	DIETICIAN CONSULTING		100.00%				33
34	V	10	NURSE CONSULTING	13,494	100.00%			(13,494)	34
35	V	17	DIR. OF OPERATIONS CONSULT	28,596	100.00%			(28,596)	35
36	V	19	DATA PROCESSING FEES	526	100.00%			(526)	36
37	V	43	MARKETING		100.00%				37
38	V								38
39	Total		\$ 42,616			\$ 51,131	\$ *	9,041	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19 PROFESSIONAL FEES	\$	8131 N. MONTICELLO, LLC	100.00%	\$ 73	\$	73	15
16	V	20 DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		22		22	16
17	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC					17
18	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC		1,758		1,758	18
19	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC		1,745		1,745	19
20	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		1,974		1,974	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34 RENT	7,095	8131 N. MONTICELLO, LLC				(7,095)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 7,095			\$ 5,572	\$ *	(1,523)	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:	
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:	
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:	
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:	
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

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

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

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

Litchfield Care Center

#

0051102

Report Period Beginning:

01/01/12

Ending:

12/31/12

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	Yosef Meystel	Relative	Administrative		See Attached	1.4	3.50%	Mgmt. Fees	\$ 3,000	17-3	1	
2	David Berkowitz	Owner	Administrative	36.50	See Attached	1.4	3.50%	Mgmt. Fees	4,000	17-3	2	
3	Joel Meystel	Relative	Administrative	N/A	See Attached	0.7	3.50%	Alloc. Salary	781	17-7	3	
4	Jay Meystel	Relative	Administrative		See Attached	0.7	1.75%	Alloc. Salary	2,078	17-7	4	
5	Fred Frankel	Owner	Administrative	1.00	See Attached	1.4	3.50%	Alloc. Salary	5,364	17-7	5	
6	Steve Turofsky	Owner	Administrative	1.00	See Attached	1.4	3.50%	Alloc. Salary	4,112	17-7	6	
7	Christina Inofre	Owner	Nursing	1.00	See Attached	1.4	3.50%	Alloc. Salary	3,544	10-07	7	
8	Cynthia Meystel	Relative	Administrative		See Attached	0.1	3.03%	Alloc. Salary	156	21-7	8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 23,035		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 Litchfield Care Center

0051102

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center

0051102

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	AVAIL. BED DAYS	697,482	17	\$ 13,451	\$ 23,790	\$ 459	1	
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	697,482	17	25,882	8,567	23,790	883	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	697,482	17	1,974	23,790	67	23,790	3
4	17	ADMINISTRATIVE	AVAIL. BED DAYS	697,482	17	361,644	361,644	23,790	12,335	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	697,482	17	22,257	23,790	759	23,790	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	697,482	17	11,509	23,790	393	23,790	6
7	21	CLERICAL & GENERAL	AVAIL. BED DAYS	697,482	17	944,249	887,220	23,790	32,207	7
8	24	SEMINARS	AVAIL. BED DAYS	697,482	17	4,715	23,790	161	23,790	8
9	25	AUTO AND TRAVEL	AVAIL. BED DAYS	697,482	17	15,759	23,790	538	23,790	9
10	26	INSURANCE	AVAIL. BED DAYS	697,482	17	23,390	23,790	798	23,790	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	697,482	17	249,963	23,790	8,526	23,790	11
12	30	DEPRECIATION	AVAIL. BED DAYS	697,482	17	19,767	23,790	674	23,790	12
13	32	INTEREST	AVAIL. BED DAYS	697,482	17	25,195	23,790	859	23,790	13
14	33	REAL ESTATE TAX	AVAIL. BED DAYS	697,482	17	-	23,790		23,790	14
15	34	RENT	AVAIL. BED DAYS	697,482	17	208,000	23,790	7,095	23,790	15
16	35	AUTO RENTAL	AVAIL. BED DAYS	697,482	17	23,725	23,790	809	23,790	16
17	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	697,482	17	3,615	23,790	123	23,790	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,955,095	\$ 1,257,431	\$ 66,686		25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center

0051102

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization YAM 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	697,482	17	\$ 130,530	\$ 122,357	23,790	\$ 4,452	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	697,482	17	22,148		23,790	755	2
3	10	NURSING SALARY	AVAIL. BED DAYS	697,482	17	621,969	621,969	23,790	21,214	3
4	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	697,482	17	27,214		23,790	928	4
5	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	697,482	17	82,340		23,790	2,808	5
6	17	ADMINISTRATIVE	AVAIL. BED DAYS	697,482	17	335,714	335,714	23,790	11,451	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	697,482	17	5,608		23,790	191	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	697,482	17	1,231		23,790	42	8
9	21	CLERICAL & GENERAL	AVAIL. BED DAYS	697,482	17	103,402	93,384	23,790	3,527	9
10	24	SEMINARS	AVAIL. BED DAYS	697,482	17	16,540		23,790	564	10
11	25	AUTO AND TRAVEL	AVAIL. BED DAYS	697,482	17	7,585		23,790	259	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	697,482	17	74,111		23,790	2,528	12
13	30	DEPRECIATION	AVAIL. BED DAYS	697,482	17	-		23,790		13
14	35	AUTO RENTAL	AVAIL. BED DAYS	697,482	17	40,201		23,790	1,371	14
15	6	REPAIRS AND MAINTENANCE	AVAIL. BED DAYS	697,482	17	30,518		23,790	1,041	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,499,111	\$ 1,173,424		\$ 51,131	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center

0051102

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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	697,482	17	\$ 2,136	\$ 20,496	\$ 73	1
2	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	697,482	17	645	20,496	22	2
3	21	OFFICE EXPENSE	AVAIL. BED DAYS	697,482	17	-	20,496		3
4	30	DEPRECIATION	AVAIL. BED DAYS	697,482	17	51,541	20,496	1,758	4
5	32	INTEREST EXPENSE	AVAIL. BED DAYS	697,482	17	51,147	20,496	1,745	5
6	33	REAL ESTATE TAXES	AVAIL. BED DAYS	697,482	17	57,872	20,496	1,974	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 163,341	\$	\$ 5,572	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center

0051102

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center

0051102

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center

0051102

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center

0051102

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center

0051102 Report Period Beginning: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center

0051102

Report Period Beginning:

01/01/12

Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Litchfield Care Center

0051102

Report Period Beginning:

01/01/12

Ending:

12/31/12

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										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	Bank Financial		X	Mortgage			\$	\$ 870,440		\$ 55,086	1								
2											2								
3											3								
4											4								
5	See Supplemental Schedule										5								
Working Capital																			
6	Bank Financial		X	Line of Credit				104,274		23,967	6								
7	Assurance		X	Insurance Financing						382	7								
8	See Supplemental Schedule										8								
9	TOTAL Facility Related						\$	\$ 974,714		\$ 79,435	9								
B. Non-Facility Related*																			
10	Allocated from YAM Managem	X								859	10								
11	Allocated from 8131 N Monticel	X								1,745	11								
12											12								
13	See Supplemental Schedule										13								
14	TOTAL Non-Facility Related						\$	\$		\$ 2,604	14								
15	TOTALS (line 9+line14)						\$	\$ 974,714		\$ 82,039	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

Litchfield Care Center

0051102

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	TOTAL Long-Term																			
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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.		\$	21,891		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.)		\$	24,414		2
3. Under or (over) accrual (line 2 minus line 1).		\$	2,523		3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	22,440		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	24,963		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2007	_____	8	FOR BHF USE ONLY	
	2008	_____	9	13	FROM R. E. TAX STATEMENT FOR 2011 \$
	2009	_____	10		
	2010	21,891	11	14	PLUS APPEAL COST FROM LINE 5 \$
	2011	22,440	12		
2012 Accrual = 2011 Tax bill				15	LESS REFUND FROM LINE 6 \$
8131 N. Monticell Allocation = \$1,974				16	AMOUNT TO USE FOR RATE CALCULATION \$

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Litchfield Care Center COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0051102

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>15-04-282-012</u>	<u>Nursing Home</u>	\$ <u>22,439.74</u>	\$ <u>22,439.74</u>
2.	<u>Allocated from 8131 N. Monticello</u>	<u>Home Office Allocation</u>	\$ <u>66,065.10</u>	\$ <u>1,974.00</u>
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u>88,504.84</u>	\$ <u>24,413.74</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

Facility Name & ID Number Litchfield Care Center

0051102

Report Period Beginning:

01/01/12

Ending:

12/31/12

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Allocated from 8131 N. Monticello</u>		<u>2010</u>	\$ <u>3,036</u>	<u>1</u>
2	<u>Facility</u>		<u>2010</u>	<u>8,241</u>	<u>2</u>
3	TOTALS			\$ 11,277	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center

0051102

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	65		2010	1971	\$ 666,776	\$ 9,229	20	\$ 19,051	\$ 9,822	\$ 44,452
5										
6										
7										
8										
	Improvement Type**									
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										
35										
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			35,938	2,134	1,268	(866)	3,106	68
69				37,054		(37,054)		69
70			\$ 702,714	\$ 48,417		\$ 20,319	\$ (28,098)	\$ 47,558 70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 702,714	\$ 48,417		\$ 20,319	\$ (28,098)	\$ 47,558	1
2	Dry Pipe Valve	2011	3,825		20	383	383	765	2
3	New Canopy	2011	5,250		20	525	525	831	3
4	Camera System	2011	6,074		20	1,215	1,215	2,126	4
5	New Roof Including Soffitt, Fascia And Gutter System	2011	59,675		20	2,984	2,984	5,719	5
6	Remove & Replace Windows & Screens	2011	65,664		20	3,283	3,283	6,293	6
7	Remove Rooftop A/C Unit, Replace With Ground Units	2011	19,554		20	978	978	1,874	7
8	Drywall Laundry Room, Break Room & Closet Ceilings, Behind C	2011	5,000		20	250	250	479	8
9	4 Outside Outlets, 6 Outside Lights, Remove Old Antenna	2011	2,940		20	147	147	282	9
10	New Landscaping, 17 Ft. Fence, Flagpole	2011	6,350		20	318	318	609	10
11	Remove And Replace Concrete At Front Door	2011	5,500		20	275	275	527	11
12	Garage - New Siding, Roof & Door	2011	4,200		20	210	210	403	12
13	Office - New P-Tech Units, Drywall, Wiring & Siding	2011	3,530		20	177	177	338	13
14	Cabinets & Countertops - Break Room, Nurse Station, Mop Room	2011	5,500		20	275	275	527	14
15	West Side - Remove & Replace Concrete	2011	4,100		20	205	205	393	15
16	Electrical For Light Fixtures And Thermoplastic Insulation	2012	21,095		20	1,406	1,406	1,406	16
17	Modify Doors & Dining Room Cabinets, Cleaned Drains	2012	15,145		20	1,515	1,515	1,515	17
18	Parking Lot	2012	41,734		20	1,390	1,390	1,390	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)		\$ 977,850	\$ 48,417		\$ 35,853	\$ (12,565)	\$ 73,034	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		\$ 977,850	\$ 48,417		\$ 35,853	\$ (12,565)	\$ 73,034	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)	\$ 977,850	\$ 48,417		\$ 35,853	\$ (12,565)	\$ 73,034	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		\$ 977,850	\$ 48,417		\$ 35,853	\$ (12,565)	\$ 73,034
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)	\$ 977,850	\$ 48,417		\$ 35,853	\$ (12,565)	\$ 73,034

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Litchfield Care Center

0051102

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 977,850	\$ 48,417		\$ 35,853	\$ (12,565)	\$ 73,034	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)	\$ 977,850	\$ 48,417		\$ 35,853	\$ (12,565)	\$ 73,034	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$	\$		\$	\$	\$
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 (12F & 12G lines 1 thru 33)	\$	\$		\$	\$	\$

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	23,587	701	20	605	(96)	1,487	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from 8131 N. Monticello	2010	10,566	1,057	20	528	(529)	1,341	9
10	Allocated from YAM Management	2010	1,124	29	20	112	83	255	10
11	Allocated from YAM Management	2012	661	347	20	23	(324)	23	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)		\$ 35,938	\$ 2,134		\$ 1,268	\$ (866)	\$ 3,106	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Litchfield Care Center

0051102

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 214,358	\$ 36,282	\$ 26,514	\$ (9,768)	10	\$ 44,611	71
72	Current Year Purchases	13,167	278	1,794	1,516	10	1,794	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 227,525	\$ 36,560	\$ 28,308	\$ (8,252)		\$ 46,405	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		2007 Ford E350- Purchased New	2011	\$ 16,615	\$	\$ 3,179	\$ 3,179	5	\$ 4,959	76
77		Allocated from YAM Manager	1900	1,160	13	301	288	5	336	77
78										78
79										79
80	TOTALS			\$ 17,775	\$ 13	\$ 3,480	\$ 3,467		\$ 5,295	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,234,427	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 84,990	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 67,641	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (17,349)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 124,734	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 6,314 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocated from YAM Management</u>		\$	\$ <u>809</u>	17
18	<u>Allocated from YAM Consulting</u>			<u>1,371</u>	18
19					19
20					20
21	TOTAL		\$	\$ <u>2,180</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2013 \$ _____

13. _____ /2014 \$ _____

14. _____ /2015 \$ _____

* 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		hrs	\$		\$				1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				1,503		1,503	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>									13
14	TOTAL			\$		\$	1,503		\$ 1,503	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 Litchfield Care Center# 0051102Report Period Beginning: 01/01/12Ending: 12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,702	\$ 18,469	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	274,303	274,303	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,355	38,355	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	74,232	(78,495)	8
9	Other(specify): <u>See Attached Schedule</u>	61,292	61,292	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 449,884	\$ 313,924	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		182,918	13
14	Buildings, at Historical Cost		330,516	14
15	Leasehold Improvements, at Historical Cost	270,962	300,377	15
16	Equipment, at Historical Cost	65,327	254,152	16
17	Accumulated Depreciation (book methods)	(63,477)	(203,985)	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>	456,620	456,620	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 729,432	\$ 1,320,598	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,179,316	\$ 1,634,522	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 910,455	\$ 910,454	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,984	7,984	28
29	Short-Term Notes Payable	104,274	104,274	29
30	Accrued Salaries Payable	114,212	114,212	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,941	5,941	31
32	Accrued Real Estate Taxes(Sch.IX-B)		22,440	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,142,866	\$ 1,165,305	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		870,440	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>		292,493	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,162,933	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,142,866	\$ 2,328,238	46
47	TOTAL EQUITY(page 18, line 24)	\$ 36,450	\$ (693,716)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,179,316	\$ 1,634,522	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 44,777	1
2	Restatements (describe):		2
3	Goodwill Adjustment	(42,500)	3
4	Rounding	3	4
5	Bad Debts	(5,000)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,720)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	60,837	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	(21,667)	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)	\$ 39,170	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)	\$ 36,450	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center

0051102

Report Period Beginning: 01/01/12

Ending:

12/31/12

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,046,442	1
2	Discounts and Allowances for all Levels	(612,536)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,433,906	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,433,906	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	493,901	31
32	Health Care	750,666	32
33	General Administration	545,608	33
B. Capital Expense			
34	Ownership	245,613	34
C. Ancillary Expense			
35	Special Cost Centers	59,712	35
36	Provider Participation Fee	277,569	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,373,069	40
41	Income before Income Taxes (line 30 minus line 40)**	60,837	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 60,837	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,332,591	44
45	Private Pay - Net Inpatient Revenue	101,315	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,433,906	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

0051102

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,891	2,170	\$ 63,400	\$ 29.22	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,899	5,414	124,024	22.91	3
4	Licensed Practical Nurses	5,695	6,136	99,656	16.24	4
5	CNAs & Orderlies	20,532	22,456	247,914	11.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	77	77	1,165	15.13	9
10	Activity Assistants	2,128	2,475	33,360	13.48	10
11	Social Service Workers	3,899	4,204	77,236	18.37	11
12	Dietician					12
13	Food Service Supervisor	87	87	1,217	13.99	13
14	Head Cook	1,309	1,507	18,475	12.26	14
15	Cook Helpers/Assistants	8,295	8,859	101,963	11.51	15
16	Dishwashers					16
17	Maintenance Workers	3,786	4,248	56,838	13.38	17
18	Housekeepers	5,042	5,590	61,039	10.92	18
19	Laundry	2,752	3,192	35,014	10.97	19
20	Administrator	1,973	2,207	88,475	40.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,404	3,847	51,660	13.43	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,725	1,876	43,050	22.95	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	67,494	74,345	\$ 1,104,486 *	\$ 14.86	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	93	\$ 5,382	01-03	35
36	Medical Director	Monthly	6,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	241	13,494	10-03	38
39	Pharmacist Consultant	76	4,639	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	54	2,965	11-03	44
45	Social Service Consultant	60	2,965	12-03	45
46	Other(specify)				46
47	<u>Psychiatric M.D.</u>	Monthly	6,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)	524	\$ 41,945		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 Litchfield Care Center

0051102

Report Period Beginning: 01/01/12

Ending: 12/31/12

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		
Barbara Lowry	Administrator	0	\$ 88,475	Workers' Compensation Insurance	\$ 40,280	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	25,259	Advertising: Employee Recruitment	187		
				FICA Taxes	83,288	Health Care Worker Background Check			
				Employee Health Insurance	30,508	(Indicate # of checks performed <u>63</u>)	633		
				Employee Meals	22	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	3,459		
				Employee Benefits - Other	532	License & Permits	508		
						Allocated from YAM Management	435		
						Allocated from 8131 N. Monticello	22		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 88,475			Less: Public Relations Expense	()		
B. Administrative - Other						Non-allowable advertising	()		
Description			Amount			Yellow page advertising	()		
Administrative Consulting - YAM Consulting			\$ 28,596						
Management Fees - Yosef Meystel			3,000						
Management Fees - David Berkowitz			4,000						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 35,596						
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
YAM Management	Bookkeeping		\$ 58,508				Out-of-State Travel	\$	
YAM Management	Accounting		12,273						
Centralia	Accounting		3,646						
FR&R	Accounting		7,515				In-State Travel		
Doral Bank	ADJ PG5A		1,212						
Galaxy Software	Data Processing		14,650						
Health Data Systems	Data Processing		3,073						
YAM Consulting	Data Processing		526				Seminar Expense	632	
YAM Management	Risk Management Services		1,000				Allocated from YAM Management	161	
LTS Solutions	Data Processing		1,700				Allocated from YAM Consulting	564	
Personnel Planners	Unemployment Consulting		850						
See Supplemental Schedule			4,585				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 109,539	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 1,357

* 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 Litchfield Care Center# 0051102

Report Period Beginning:

01/01/12

Ending:

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

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$6,123
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 277,569
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. \$ 22 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% line 14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT