FOR BHF USE

LL1

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

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0051086

Facility Name: Springfield Care Center

Address: 525 S. Martin Luther King Dr. (Number) Springfield (City) 62703 (Zip Code)

County: Sangamon

Telephone Number: (217)789-1680 **Fax #** (217)789-0842

HFS ID Number:

Date of Initial License for Current Owners: 09/01/10

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Cary C. Buxbaum, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center # 0051086 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	21,724	534	215	22,473	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,724	534	215	22,473	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.46%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 9/1/2010

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	99,086	7,901	6,636	113,623		113,623	4,452	118,075			1
2	Food Purchase		108,040		108,040		108,040	(26)	108,014			2
3	Housekeeping	90,176	8,361		98,537		98,537		98,537			3
4	Laundry	309	9,075		9,384		9,384		9,384			4
5	Heat and Other Utilities			61,116	61,116		61,116	(494)	60,622			5
6	Maintenance	26,090	11,893	59,241	97,224		97,224	6,929	104,153			6
7	Other (specify):*							822	822			7
8	TOTAL General Services	215,661	145,270	126,993	487,924		487,924	11,683	499,607			8
	B. Health Care and Programs											
9	Medical Director			10,800	10,800		10,800		10,800			9
10	Nursing and Medical Records	628,928	29,377	22,489	680,794		680,794	6,814	687,608			10
10a	Therapy											10a
11	Activities	43,393	4,303	1,135	48,831		48,831		48,831			11
12	Social Services	69,377		2,755	72,132		72,132		72,132			12
13	CNA Training											13
14	Program Transportation			1,704	1,704		1,704	928	2,632			14
15	Other (specify):*							2,808	2,808			15
16	TOTAL Health Care and Programs	741,698	33,680	38,883	814,261		814,261	10,550	824,811			16
	C. General Administration											
17	Administrative	61,683		39,202	100,885		100,885	(8,416)	92,469			17
18	Directors Fees											18
19	Professional Services			105,441	105,441		105,441	(68,616)	36,825			19
20	Dues, Fees, Subscriptions & Promotions			14,710	14,710		14,710	(4,937)	9,773			20
21	Clerical & General Office Expenses	21,621		28,696	50,317		50,317	26,749	77,066			21
22	Employee Benefits & Payroll Taxes			153,666	153,666		153,666		153,666			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,365	1,365		1,365	725	2,090			24
25	Other Admin. Staff Transportation			14,941	14,941		14,941	797	15,738			25
26	Insurance-Prop.Liab.Malpractice			26,723	26,723		26,723	798	27,521			26
27	Other (specify):*							11,054	11,054			27
28	TOTAL General Administration	83,304		384,744	468,048		468,048	(41,846)	426,202			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,040,663	178,950	550,620	1,770,233		1,770,233	(19,613)	1,750,620			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Springfield Care Center #0051086 Report Period Beginning: 01/01/12 Ending: 12/31/12

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			32,303	32,303		32,303	31,321	63,624			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,654	17,654		17,654	55,982	73,636			32
33	Real Estate Taxes							18,877	18,877			33
34	Rent-Facility & Grounds			170,903	170,903		170,903	(170,903)				34
35	Rent-Equipment & Vehicles			3,655	3,655		3,655	2,303	5,958			35
36	Other (specify):*			1,031	1,031		1,031	(1,031)	0			36
37	**TOTAL Ownership**			225,546	225,546		225,546	(63,451)	162,095			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			268,324	268,324		268,324		268,324			42
43	Other (specify):*			50,650	50,650		50,650	(55,650)	(5,000)			43
44	**TOTAL Special Cost Centers**			318,974	318,974		318,974	(55,650)	263,324			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,040,663	178,950	1,095,140	2,314,753		2,314,753	(138,713)	2,176,040			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 Ending: 12/31/12

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 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	(953)	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	(15,529)	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	(26)	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	(815)	21		19
20	Contributions	(2,500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals	(5,000)	43		23
24	Bad Debt	(2,470)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(59,808)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (87,125)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 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)	(51,588)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (51,588)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (138,713)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Springfield Care Center

ID# 0051086

Report Period Beginning: 01/01/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Expense	$ (231)	43	1
2	Bank Charges	(5,063)	21	2
3	Theft & Damage Loss	(611)	21	3
4	Amortization	(1,031)	36	4
5	Interest Income	(131)	32	5
6	Other Unclassified Income	(1)	21	6
7	Building Co. - Bank Charges	(77)	21	7
8	Building Co. - License & Permits	(250)	20	8
9	Building Co. - Professional Fees	(2,500)	19	9
10	Additional R&M	5,005	06	10
11	Professional Fees	(393)	19	11
12	COPE dues	(2,894)	20	12
13	Non-allowable Expense	(50,419)	43	13
14	Non-allowable Legal Fees	(1,212)	19	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**	(59,808)		49

Springfield Care Center

ID# 0051086

Report Period Beginning: 01/01/12

Ending: 12/31/12

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Springfield Care Center # 0051086 **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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				4,452								4,452	1
2	Food Purchase	(26)											(26)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(953)		459									(494)	5
6	Maintenance	5,005		883	1,041								6,929	6
7	Other (specify):*			67	755								822	7
8	**TOTAL General Services**	4,026		1,409	6,248								11,683	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				6,814								6,814	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**				10,550								10,550	16
	C. General Administration													
17	Administrative			12,335	(20,751)								(8,416)	17
18	Directors Fees													18
19	Professional Services	(4,105)	(1,133)	(63,642)	191	73							(68,616)	19
20	Fees, Subscriptions & Promotions	(5,644)	250	393	42	22							(4,937)	20
21	Clerical & General Office Expenses	(9,062)	77	32,207	3,527								26,749	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**	(18,811)	(806)	(8,684)	(13,640)	95							(41,846)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,785)	(806)	(7,275)	3,158	95							(19,613)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Springfield Care Center # 0051086 **Report Period Beginning:** 01/01/12 **Ending:** 12/31/12

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(15,529)	44,418	674		1,758							31,321	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(131)	53,509	859		1,745							55,982	32
33	Real Estate Taxes		16,903			1,974							18,877	33
34	Rent-Facility & Grounds		(158,903)	(4,905)		(7,095)							(170,903)	34
35	Rent-Equipment & Vehicles			932	1,371								2,303	35
36	Other (specify):*	(1,031)											(1,031)	36
37	**TOTAL Ownership**	(16,691)	(44,073)	(2,440)	1,371	(1,618)							(63,451)	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):*	(55,650)											(55,650)	43
44	**TOTAL Special Cost Centers**	(55,650)											(55,650)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(87,125)	(44,879)	(9,715)	4,529	(1,523)							(138,713)	45

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 Ending: 12/31/12

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 158,903	Centralia Property LLC	100.00%	$	$ (158,903)	1
2	V	21	Bank Charges		Centralia Property LLC	100.00%	77	77	2
3	V	20	Business Licenses & Permits		Centralia Property LLC	100.00%	250	250	3
4	V	30	Depreciation Expense		Centralia Property LLC	100.00%	44,418	44,418	4
5	V	19	Professional Fees		Centralia Property LLC	100.00%	2,500	2,500	5
6	V	33	Real Estate Tax		Centralia Property LLC	100.00%	16,903	16,903	6
7	V	32	Interest Expense		Centralia Property LLC	100.00%	53,509	53,509	7
8	V	19	Accounting	3,633	Centralia Property LLC	100.00%		(3,633)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 162,536			$ 117,657	$ * (44,879)	14

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

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 Ending: 12/31/12

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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	51,128	YAM MANAGEMENT, LLC	100.00%		(51,128)	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	19	PROFESSIONAL FEES	1,000	YAM MANAGEMENT, LLC	100.00%		(1,000)	38
39	Total			$ 76,401			$ 66,686	$ * (9,715)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 Ending: 12/31/12

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	YAM CONSULTING, LLC	100.00%	$ 4,452	$ 4,452	15
16	V	7	EMP. BEN. GEN. SERV.		YAM CONSULTING, LLC	100.00%	755	755	16
17	V	10	NURSING SALARY		YAM CONSULTING, LLC	100.00%	21,214	21,214	17
18	V	14	PROGRAM TRANSPORTATION		YAM CONSULTING, LLC	100.00%	928	928	18
19	V	15	EMP. BEN. HEALTHCARE		YAM CONSULTING, LLC	100.00%	2,808	2,808	19
20	V	17	ADMINISTRATIVE		YAM CONSULTING, LLC	100.00%	11,451	11,451	20
21	V	19	PROFESSIONAL FEES		YAM CONSULTING, LLC	100.00%	191	191	21
22	V	20	FEES, SUBSCRIPTIONS		YAM CONSULTING, LLC	100.00%	42	42	22
23	V	21	CLERICAL & GENERAL		YAM CONSULTING, LLC	100.00%	3,527	3,527	23
24	V	24	SEMINARS		YAM CONSULTING, LLC	100.00%	564	564	24
25	V	25	AUTO AND TRAVEL		YAM CONSULTING, LLC	100.00%	259	259	25
26	V	27	EMP. BEN.-GEN. ADMIN.		YAM CONSULTING, LLC	100.00%	2,528	2,528	26
27	V	30	DEPRECIATION		YAM CONSULTING, LLC	100.00%			27
28	V	35	AUTO RENTAL		YAM CONSULTING, LLC	100.00%	1,371	1,371	28
29	V	6	REPAIRS AND MAINTENANCE SALARY		YAM CONSULTING, LLC	100.00%	1,041	1,041	29
30	V								30
31	V								31
32	V								32
33	V	1	DIETICIAN CONSULTING		YAM CONSULTING, LLC	100.00%			33
34	V	10	NURSE CONSULTING	14,400	YAM CONSULTING, LLC	100.00%		(14,400)	34
35	V	17	DIR. OF OPERATIONS CONSULT	32,202	YAM CONSULTING, LLC	100.00%		(32,202)	35
36	V	19	DATA PROCESSING FEES		YAM CONSULTING, LLC	100.00%			36
37	V	43	MARKETING		YAM CONSULTING, LLC	100.00%			37
38	V								38
39	Total			$ 46,602			$ 51,131	$ * 4,529	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 Ending: 12/31/12

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.**

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.**

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 Ending: 12/31/12

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	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%	LITCHFIELD CARE CENTER,LLC	LITCHFIELD				9
10	42170 LIMITED PARTNERSHIP	2.500%	NORTH CHURCH NURSING & REHAB,LLC	JACKSONVILLE				10
11	1219 LIMITED PARTNERSHIP	2.500%	PLAZA NURSING AND REHAB CENTER,LLC	MIDLOTHIAN				11
12	906 LLC	2.500%	PLUM GROVE NURSING AND REHAB,LLC	PALATINE				12
13	CONGREGATION OF TIFERES AVROHOM	2.500%	RIVIERA CARE CENTER,LLC	CHICAGO HEIGHTS				13
14			THE ARBOR	MICHIGAN CITY, IN				14
15			COPPERAS HOLLOW	CALDWELL, TX				15
16			COPPERAS HOLLOW	CALDWELL, TX				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 Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 Ending: 12/31/12

VII. RELATED PARTIES

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

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

Facility Name & ID Number Springfield Care Center # 0051086 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Relative	Administrative		See Attached	1.4	3.50%	Consult. Fees	$ 3,000	17-3	1
2	David Berkowitz	Owner	Administrative	36.50	See Attached	1.4	3.50%	Consult. 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	10-7	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

Facility Name & ID Number Springfield Care Center # 0051086 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 [X]

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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	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	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	697,482	17	11,509		23,790	393	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	8
9	25	AUTO AND TRAVEL	AVAIL. BED DAYS	697,482	17	15,759		23,790	538	9
10	26	INSURANCE	AVAIL. BED DAYS	697,482	17	23,390		23,790	798	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	697,482	17	249,963		23,790	8,526	11
12	30	DEPRECIATION	AVAIL. BED DAYS	697,482	17	19,767		23,790	674	12
13	32	INTEREST	AVAIL. BED DAYS	697,482	17	25,195		23,790	859	13
14	33	REAL ESTATE TAX	AVAIL. BED DAYS	697,482	17	-		23,790		14
15	34	RENT	AVAIL. BED DAYS	697,482	17	208,000		23,790	7,095	15
16	35	AUTO RENTAL	AVAIL. BED DAYS	697,482	17	23,725		23,790	809	16
17	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	697,482	17	3,615		23,790	123	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 Springfield Care Center # 0051086 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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 Springfield Care Center # 0051086 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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 Springfield Care Center # 0051086 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 Ending: 12/31/12

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Ally		X	Auto Loan			$	$ 35,149			$ 1,641	1
2	Bank Financial		X	Mortgage				845,530			53,509	2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Bank Financial		X	Line of Credit				185,775			15,652	6
7	Assurance		X	Insurance Financing							361	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 1,066,453			$ 71,162	9
	B. Non-Facility Related*											
10	Interest Income		X								(131)	10
11	YAM Management Allocation	X									859	11
12	8131 N Monticello Allocation	X									1,745	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ 2,473	14
15	TOTALS (line 9+line14)						$	$ 1,066,453			$ 73,635	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 Springfield Care Center # 0051086 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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Springfield Care Center # 0051086 **Report Period Beginning:** 01/01/12 **Ending:** 12/31/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 16,079	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.)		$ 18,465	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,386	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 16,491	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.		$ 18,877	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2007		8
2008		9
2009		10
2010	16,079	11
2011	16,491	12

2012 Accrual = 2011 Tax

8131 N Monticello Allocation = $1,974

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Springfield Care Center COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0051086

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-35.0-157-019	Nursing Home	$ 16,490.98	$ 16,490.98
2.	Allocated from 8131 N. Monticello	Home Office Allocation	$ 66,065.10	$ 1,973.93
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 82,556.08	$ 18,464.91

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Springfield Care Center COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0051086

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

A. **Summary of Real Estate Tax Cost**

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Springfield Care Center # 0051086 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 [X] (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? [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Centralia Property LLC			$ 182,918	1
2	Allocated from 8131 N Monticello			3,036	2
3	TOTALS			$ 185,954	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center # 0051086 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	65		2011	1972	$ 639,905	$ 9,396	20	$ 18,283	$ 8,887	$ 42,660	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Springfield Care Center # 0051086 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		35,938	2,134		1,268	(866)	3,106	68
69	Financial Statement Depreciation			32,303			(32,303)		69
70	TOTAL (lines 4 thru 69)		$ 675,843	$ 43,833		$ 19,551	$ (24,282)	$ 45,766	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 675,843	$ 43,833		$ 19,551	$ (24,282)	$ 45,766	1
2	Bathroom Tile, Grout, Walls	2011	13,000		20	1,300	1,300	2,058	2
3	Water Heater	2011	6,082		20	1,216	1,216	1,825	3
4	3 Bathrooms & Hall Remodel, Walls, Titles, Fixtures, Sinks, Toilet	2012	22,000		20	917	917	917	4
5	Hvac-Condensing Unit & Air Handlers	2012	20,500		20	769	769	769	5
6	New Asphalt	2012	12,836		20	713	713	713	6
7	50 Wall Units With Sleeves	2012	32,650		20	2,721	2,721	2,721	7
8	48 Window Units	2012	42,000		20	2,100	2,100	2,100	8
9	Phone System	2012	4,646		20	619	619	619	9
10	Patio & Patio Door Repairs	2012	4,750		20	238	238	238	10
11	Kitchen Remodel- Walls, Cabinets, & Countertop	2012	3,000		20	150	150	150	11
12	Sink, Disposer, & Redo Plumbing	2012	8,558		20	428	428		12
13	Water Heater	2012	4,200		20	210	210		13
14	Electric Breakers	2012	6,467		20	323	323		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)		$ 856,532	$ 43,833		$ 31,255	$ (12,578)	$ 57,875	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 856,532	$ 43,833		$ 31,255	$ (12,578)	$ 57,875	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)		$ 856,532	$ 43,833		$ 31,255	$ (12,578)	$ 57,875	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 856,532	$ 43,833		$ 31,255	$ (12,578)	$ 57,875	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
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19									19
20									20
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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)		$ 856,532	$ 43,833		$ 31,255	$ (12,578)	$ 57,875	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 856,532	$ 43,833		$ 31,255	$ (12,578)	$ 57,875	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)		$ 856,532	$ 43,833		$ 31,255	$ (12,578)	$ 57,875	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 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 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.

Facility Name & ID Number Springfield Care Center # 0051086 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 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 Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$	$		$	$	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Springfield Care Center # 0051086 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 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	39	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.

Facility Name & ID Number Springfield Care Center # 0051086 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 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 Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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16									16
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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 Springfield Care Center # 0051086 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	$ 213,161	$ 35,029	$ 26,058	$ (8,971)	10	$ 45,906	71
72	Current Year Purchases	5,293	278	906	628	10	906	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 218,454	$ 35,307	$ 26,964	$ (8,343)		$ 46,812	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2010 FORD E350 - Transfer from	2012	$ 47,641	$	$ 5,104	$ 5,104	5	$ 5,104	76
77		Allocated from YAM Managemer	2009	1,160	13	301	288	5	336	77
78										78
79										79
80	TOTALS			$ 48,801	$ 13	$ 5,405	$ 5,392		$ 5,440	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)	$	1,309,741	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	79,153	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	63,625	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(15,529)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	110,128	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.

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 Ending: 12/31/12

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: *

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	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 3,778 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 Ending: 12/31/12

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	1	2	3	4	5	6	7	8	
	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	N/A	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental									13
14	TOTAL			$		$	$		$	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Springfield Care Center **#** 0051086 **Report Period Beginning:** 01/01/12 **Ending:** 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	$ 3,338	$ 13,589	1
2	Cash-Patient Deposits	7,850	7,850	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	290,096	290,096	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	37,072	37,072	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	142,468	(9,971)	8
9	Other(specify): See Attached Schedule	19,081	19,081	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 499,905	$ 357,717	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		342,849	14
15	Leasehold Improvements, at Historical Cost	80,898	104,510	15
16	Equipment, at Historical Cost	183,483	365,778	16
17	Accumulated Depreciation (book methods)	(46,891)	(183,656)	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): See Attached Schedule	456,620	456,620	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 674,110	$ 1,269,019	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,174,015	$ 1,626,736	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,138,557	$ 1,138,557	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,142	21,142	28
29	Short-Term Notes Payable	195,817	195,817	29
30	Accrued Salaries Payable	82,718	82,718	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,753	8,753	31
32	Accrued Real Estate Taxes(Sch.IX-B)		16,491	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,446,987	$ 1,463,478	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	25,106	25,106	39
40	Mortgage Payable		845,530	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule		292,493	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 25,106	$ 1,163,129	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,472,093	$ 2,626,607	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (298,078)	$ (999,871)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,174,015	$ 1,626,736	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 Ending: 12/31/12

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (124,084)	1
2	Restatements (describe):		2
3	**Goodwill Adjustment**	(42,500)	3
4	**Bad debts**	(5,000)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (171,584)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(104,827)	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)**	$ (126,494)	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)**	$ (298,078)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,248,845	1
2	Discounts and Allowances for all Levels	(1,039,201)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,209,644	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***	131	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 131	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	151	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 151	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,209,926	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	487,924	31
32	Health Care	814,261	32
33	General Administration	468,048	33
	B. Capital Expense		
34	Ownership	225,546	34
	C. Ancillary Expense		
35	Special Cost Centers	50,650	35
36	Provider Participation Fee	268,324	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,314,753	40
41	**Income before Income Taxes (line 30 minus line 40)****	(104,827)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (104,827)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,114,034	44
45	Private Pay - Net Inpatient Revenue	74,760	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)	20,850	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,209,644	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,014	2,055	$ 57,550	$ 28.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,942	3,128	66,026	21.11	3
4	Licensed Practical Nurses	8,324	8,829	165,536	18.75	4
5	CNAs & Orderlies	23,631	25,871	276,044	10.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,672	3,823	43,393	11.35	10
11	Social Service Workers	3,898	4,135	69,377	16.78	11
12	Dietician					12
13	Food Service Supervisor	1,924	2,091	27,189	13.00	13
14	Head Cook	3,479	3,769	34,482	9.15	14
15	Cook Helpers/Assistants	3,765	3,947	37,415	9.48	15
16	Dishwashers					16
17	Maintenance Workers	2,018	2,174	26,090	12.00	17
18	Housekeepers	8,486	9,045	90,176	9.97	18
19	Laundry	35	35	309	8.83	19
20	Administrator	2,053	2,138	61,683	28.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,052	2,136	21,621	10.12	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	2,162	2,280	63,772	27.97	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	70,455	75,456	$ 1,040,663 *	$ 13.79	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	120	$ 6,636	01-03	35
36	Medical Director	Monthly	10,800	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	191	14,400	10-03	38
39	Pharmacist Consultant	48	2,466	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	21	1,135	11-03	44
45	Social Service Consultant	57	2,755	12-03	45
46	Other(specify)				46
47	Psychiatric MD	Monthly	5,623	10-03	47
48					48
49	TOTAL (lines 35 - 48)	437	$ 43,815		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jacqueline Liddell	Administrator	0.00	$ 61,683
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 61,683

B. Administrative - Other

Description	Amount
Administrative Consulting - YAM Consulting	$ 32,202
Management Fees - Yosef Meystel	3,000
Management Fees - David Berkowitz	4,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 39,202
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
YAM Management	Bookkeeping	$ 51,128
YAM Management	Accounting	12,273
Centralia	Accounting	3,633
FR&R	Accounting	9,175
Health Data Systems	Data Processing	3,223
YAM Management	Data Processing	787
Galaxy Hosted Software	Data Processing	14,650
LTC Solutions	Data Processing	1,700
Holland & Knight	Legal Fees	3,502
Legal	ADJ PG5A	1,212
Personnel Planners	Unemployment Consulting	1,592
See Supplemetal Schedule		2,564
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 105,440

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 24,953
Unemployment Compensation Insurance	39,999
FICA Taxes	78,641
Employee Health Insurance	9,545
Employee Meals	84
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits Other	443
TOTAL (agree to Schedule V, line 22, col.8)	$ 153,666

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	1,507
Health Care Worker Background Check	
(Indicate # of checks performed 149)	1,485
Patient Background Checks	
Dues & Subscriptions	6,153
License & Permits	1,075
Allocated from YAM Management	435
Allocated from 8131 N Monticello	22
Less: Public Relations Expense	(2,894)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,772

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,365
Allocated from YAM Management	161
Allocated from YAM Consulting	564
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,090

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Springfield Care Center # 0051086 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Springfield Care Center # 0051086 **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?

(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. $ **268,324**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **84** 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% of line14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.