

Facility Name & ID Number Litchfield Care Center

0051102 Report Period Beginning: 01/01/13 Ending: 12/31/13

III. STATISTICAL DATA

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

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	65	Intermediate (ICF)	65	23,725	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	65	TOTALS	65	23,725	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	21,726	717		22,443
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	21,726	717		22,443

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.60%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 09/01/2010

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

YES Date 09/01/2010 NO

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Litchfield Care Center

0051102

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	116,582	10,157	3,655	130,394		130,394	4,870	135,264		1
2	Food Purchase		101,983		101,983		101,983	(33)	101,950		2
3	Housekeeping	62,325	8,888		71,213		71,213		71,213		3
4	Laundry	41,634	8,024		49,658		49,658		49,658		4
5	Heat and Other Utilities			52,700	52,700		52,700	62	52,762		5
6	Maintenance	60,400	5,206	23,970	89,576		89,576	6,585	96,161		6
7	Other (specify):*							874	874		7
8	TOTAL General Services	280,941	134,258	80,325	495,524		495,524	12,358	507,882		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	563,937	24,431	23,423	611,791		611,791	3,513	615,304		10
10a	Therapy										10a
11	Activities	33,436	3,353	2,714	39,503		39,503		39,503		11
12	Social Services	74,042		2,041	76,083		76,083		76,083		12
13	CNA Training										13
14	Program Transportation							1,157	1,157		14
15	Other (specify):*							2,613	2,613		15
16	TOTAL Health Care and Programs	671,415	27,784	34,178	733,377		733,377	7,283	740,660		16
	C. General Administration										
17	Administrative	60,600		43,029	103,629		103,629	(16,714)	86,915		17
18	Directors Fees										18
19	Professional Services			135,337	135,337		135,337	(81,179)	54,158		19
20	Dues, Fees, Subscriptions & Promotions			12,944	12,944		12,944	(2,843)	10,101		20
21	Clerical & General Office Expenses	46,643	325	44,132	91,100		91,100	9,988	101,088		21
22	Employee Benefits & Payroll Taxes			129,103	129,103		129,103		129,103		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,886	1,886		1,886	389	2,275		24
25	Other Admin. Staff Transportation			9,628	9,628		9,628	2,178	11,806		25
26	Insurance-Prop.Liab.Malpractice			33,461	33,461		33,461	724	34,185		26
27	Other (specify):*							12,498	12,498		27
28	TOTAL General Administration	107,243	325	409,520	517,088		517,088	(74,959)	442,129		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,059,599	162,367	524,023	1,745,989		1,745,989	(55,317)	1,690,672		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Litchfield Care Center

#0051102

Report Period Beginning:

01/01/13

Ending:

12/31/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			40,175	40,175	40,175	28,152	68,327				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,939	15,939	15,939	44,794	60,733				32
33	Real Estate Taxes						23,636	23,636				33
34	Rent-Facility & Grounds			189,891	189,891	189,891	(189,891)					34
35	Rent-Equipment & Vehicles			5,772	5,772	5,772	1,877	7,649				35
36	Other (specify):*			4,123	4,123	4,123	(4,123)					36
37	TOTAL Ownership			255,900	255,900	255,900	(95,555)	160,345				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			137,551	137,551	137,551		137,551				42
43	Other (specify):*			58,341	58,341	58,341	(58,341)	(0)				43
44	TOTAL Special Cost Centers			195,892	195,892	195,892	(58,341)	137,551				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,059,599	162,367	975,815	2,197,781	2,197,781	(209,213)	1,988,568				45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center

0051102

Report Period Beginning: 01/01/13

Ending: 12/31/13

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(395)	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	(23,293)	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	(33)	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				18
19	Entertainment	(2,600)	21		19
20	Contributions	(1,250)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,664)	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	(85,853)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (118,087)		\$	30

BHF USE ONLY					
48		49	50	51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(91,126)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (91,126)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (209,213)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Litchfield Care Center

ID# 0051102

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Bank Charges	\$ (24,460)	21	1
2	Theft & Damage Loss	(495)	21	2
3	Amortization	(4,123)	36	3
4	Bldg. Company - Bank Charges	(318)	21	4
5	Bldg. Company - License & Fees	(250)	20	5
6	Additional R&M	3,647	06	6
7	COPE Dues	(2,908)	20	7
8	Non-allowable Legal Fees	(105)	19	8
9	Non-allowable Fees	(55,770)	43	9
10	Advertising/Marketing	(1,071)	43	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(85,853)	49

Litchfield Care Center

ID# 0051102

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Litchfield Care Center# 0051102

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				4,870								4,870	1
2	Food Purchase	(33)											(33)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(395)		457									62	5
6	Maintenance	3,647		801	2,137								6,585	6
7	Other (specify):*			68	806								874	7
8	TOTAL General Services	3,219		1,326	7,813								12,358	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				3,513								3,513	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation				1,157								1,157	14
15	Other (specify):*				2,613								2,613	15
16	TOTAL Health Care and Programs				7,283								7,283	16
	C. General Administration													
17	Administrative			10,848	(27,562)								(16,714)	17
18	Directors Fees													18
19	Professional Services	(105)	(1,250)	(76,226)	(2,725)	136	(1,009)						(81,179)	19
20	Fees, Subscriptions & Promotions	(4,408)	250	304	1,004	7							(2,843)	20
21	Clerical & General Office Expenses	(32,537)	318	34,187	7,961	59							9,988	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			126	263								389	24
25	Other Admin. Staff Transportation			1,170	1,008								2,178	25
26	Insurance-Prop.Liab.Malpractice			601	123								724	26
27	Other (specify):*			9,147	3,351								12,498	27
28	TOTAL General Administration	(37,050)	(682)	(19,843)	(16,577)	202	(1,009)						(74,959)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(33,830)	(682)	(18,517)	(1,481)	202	(1,009)						(55,317)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Litchfield Care Center

0051102

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(23,293)	49,182	733		1,530							28,152	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		42,758	604		1,432							44,794	32
33	Real Estate Taxes		21,830			1,806							23,636	33
34	Rent-Facility & Grounds		(177,891)	(6,703)		(5,297)							(189,891)	34
35	Rent-Equipment & Vehicles			789	1,088								1,877	35
36	Other (specify):*	(4,123)											(4,123)	36
37	TOTAL Ownership	(27,416)	(64,121)	(4,577)	1,088	(529)							(95,555)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(56,841)			(1,500)								(58,341)	43
44	TOTAL Special Cost Centers	(56,841)			(1,500)								(58,341)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(118,087)	(64,803)	(23,094)	(1,893)	(327)	(1,009)						(209,213)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 177,891	Centralia Property, LLC	100.00%	\$	\$ (177,891)	1
2	V	21 Bank Charges		Centralia Property, LLC		318	318	2
3	V	30 Depreciation Expense				49,182	49,182	3
4	V	20 License and Fees				250	250	4
5	V	33 Real Estate Tax				22,135	22,135	5
6	V	33 Real Estate Tax - PY	305				(305)	6
7	V	32 Interest Expense				42,758	42,758	7
8	V	19 Accounting	1,250				(1,250)	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 179,446			\$ 114,643	\$ * (64,803)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	YAM MANAGEMENT, LLC	100.00%	\$ 457	\$	457	15
16	V	6 REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	801		801	16
17	V	7 EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	68		68	17
18	V	17 ADMINISTRATIVE		YAM MANAGEMENT, LLC	100.00%	10,848		10,848	18
19	V	19 PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	1,959		1,959	19
20	V	20 FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	304		304	20
21	V	21 CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	34,187		34,187	21
22	V	24 SEMINARS		YAM MANAGEMENT, LLC	100.00%	126		126	22
23	V	25 AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	1,170		1,170	23
24	V	26 INSURANCE		YAM MANAGEMENT, LLC	100.00%	601		601	24
25	V	27 EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	9,147		9,147	25
26	V	30 DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	733		733	26
27	V	32 INTEREST		YAM MANAGEMENT, LLC	100.00%	604		604	27
28	V	33 REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%				28
29	V	34 RENT		YAM MANAGEMENT, LLC	100.00%	5,297		5,297	29
30	V	35 AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	789		789	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V	19 BOOKKEEPING FEES	62,675	YAM MANAGEMENT, LLC	100.00%			(62,675)	35
36	V	19 ACCOUNTING	12,000	YAM MANAGEMENT, LLC	100.00%			(12,000)	36
37	V	34 RENT	12,000	YAM MANAGEMENT, LLC	100.00%			(12,000)	37
38	V	19 PROFESSIONAL FEES	3,510	YAM MANAGEMENT, LLC	100.00%			(3,510)	38
39	Total		\$ 90,185			\$ 67,091	\$ *	(23,094)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1	DIETARY	YAM CONSULTING, LLC	100.00%	\$ 4,870	\$ 4,870
16	V	7	EMP. BEN. GEN. SERV.	YAM CONSULTING, LLC	100.00%	806	806
17	V	10	NURSING SALARY	YAM CONSULTING, LLC	100.00%	18,813	18,813
18	V	14	PROGRAM TRANSPORTATION	YAM CONSULTING, LLC	100.00%	1,157	1,157
19	V	15	EMP. BEN. HEALTHCARE	YAM CONSULTING, LLC	100.00%	2,613	2,613
20	V	17	ADMINISTRATIVE	YAM CONSULTING, LLC	100.00%	10,438	10,438
21	V	19	PROFESSIONAL FEES	YAM CONSULTING, LLC	100.00%	565	565
22	V	20	FEES, SUBSCRIPTIONS	YAM CONSULTING, LLC	100.00%	1,004	1,004
23	V	21	CLERICAL & GENERAL	YAM CONSULTING, LLC	100.00%	7,961	7,961
24	V	24	SEMINARS	YAM CONSULTING, LLC	100.00%	263	263
25	V	25	AUTO AND TRAVEL	YAM CONSULTING, LLC	100.00%	1,008	1,008
26	V	27	EMP. BEN.-GEN. ADMIN.	YAM CONSULTING, LLC	100.00%	3,351	3,351
27	V	26	INSURANCE	YAM CONSULTING, LLC	100.00%	123	123
28	V	35	AUTO RENTAL	YAM CONSULTING, LLC	100.00%	1,088	1,088
29	V	6	REPAIRS AND MAINTENANCE SALARY	YAM CONSULTING, LLC	100.00%	2,137	2,137
30	V						
31	V						
32	V	06	PAINTER	YAM CONSULTING, LLC	100.00%		
33	V	01	DIETICIAN CONSULTING	YAM CONSULTING, LLC	100.00%		
34	V	10	NURSE CONSULTING	YAM CONSULTING, LLC	100.00%		(15,300)
35	V	17	DIR. OF OPERATIONS CONSULT	YAM CONSULTING, LLC	100.00%		(38,000)
36	V	19	DATA PROCESSING FEES	YAM CONSULTING, LLC	100.00%		(3,290)
37	V	43	MARKETING	YAM CONSULTING, LLC	100.00%		(1,500)
38	V	06	PROJECT MANAGER INCOME	YAM CONSULTING, LLC	100.00%		
39	Total		\$ 58,090			\$ 56,197	\$ * (1,893)

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19 PROFESSIONAL FEES	\$	8131 N. MONTICELLO, LLC	100.00%	\$ 136	\$	136	15
16	V	20 DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		7		7	16
17	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC		59		59	17
18	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC		1,530		1,530	18
19	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC		1,432		1,432	19
20	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		1,806		1,806	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34 RENT	5,297	8131 N. MONTICELLO, LLC				(5,297)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 5,297			\$ 4,970	\$ *	(327)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Payroll Services	\$ 7,760	ProPay HR LLC	66.67%	\$ 6,751	\$ (1,009)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 7,760			\$ 6,751	\$ * (1,009)

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ML EQUITY PARTNERS LLC	5.00%	BERKSHIRE NURSING & REHAB CENTER,LLC	FOREST PARK	YAM MANAGEMENT	SKOKIE	MANAGEMENT CO.	1
2	MARTIN LOEB	2.00%	CONCORD NURSING AND REHABILITATION CENTER,LLC	OAK LAWN	YAM CONSULTING	SKOKIE	CONSULTING CO.	2
3	HOWARD SUSS	5.00%	DOLTON NURSING & REHAB,LLC	DOLTON	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	3
4	DAVID BERKOWITZ	36.50%	EVANSTON NURSING & REHAB CENTER, LLC	EVANSTON	CENTRALIA PROPERTY, LLC	SKOKIE	BUILDING CO.	4
5	DECLARATION OF TRUST OF YOSEF MEYSEL	34.50%	EXCEPTIONAL CARE, LLC	BURBANK	PROPAY	EVANSTON	PAYROLL SERVICES	5
6	JAY MEYSEL TRUST	4.00%	HIGHLAND PARK NURSING AND REHAB CENTER, LLC	HIGHWOOD	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	6
7	STEVEN TUROFSKY	1.00%	INTERNATIONAL NURSING & REHAB CENTER,LLC	CHICAGO	ROOSEVELT RISK MANAGEM	SKOKIE	CAPTIVE INSURANCE	7
8	FREDERICK S. FRANKEL	1.00%	NORTH CHURCH NURSING & REHAB,LLC	JACKSONVILLE				8
9	CHRISTINA INOFRE	1.00%	PLAZA NURSING AND REHAB CENTER,LLC	MIDLOTHIAN				9
10	42170 LIMITED PARTNERSHIP	2.50%	PLUM GROVE NURSING AND REHAB,LLC	PALATINE				10
11	1219 LIMITED PARTNERSHIP	2.50%	RIVIERA CARE CENTER,LLC	CHICAGO HEIGHTS				11
12	417A, LLC	2.50%	SPRINGFIELD CARE CENTER,LLC	SPRINGFIELD				12
13	257 LTD. PARTNERSHIP	2.50%	THE ARBOR	MICHIGAN CITY, IN				13
14			COPPERAS HOLLOW	CALDWELL, TX				14
15			ISLAND CITY REHAB CENTER	WILMINGTON				15
16			LINCOLN REHAB	DECATUR				16
17			RIVERWOOD REHAB	EAST MOLINE				17
18			RIVER CROSSING REHAB	GALESBURG				18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Litchfield Care Center

0051102

Report Period Beginning:

01/01/13

Ending:

12/31/13

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center # 0051102 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Relative	Administrative		See Attached	1.2	3.00%	Mgmt Fees	\$ 2,188	17-3	1
2	David Berkowitz	Owner	Administrative	36.50%	See Attached	1.2	3%	Mgmt Fees	2,841	17-3	2
3	Joel Meystel	Relative	Administrative		See Attached	0.6	3%	Alloc. Salary	729	17-7	3
4	Jay Meystel	Relative	Administrative		See Attached	0.6	2%	Alloc. Salary	1,776	17-7	4
5	Fred Frankel	Owner	Administrative	1.00%	See Attached	1.2	3%	Alloc. Salary	4,456	17-7	5
6	Steve Turofsky	Owner	Administrative	1.00%	See Attached	1.2	3%	Alloc. Salary	3,887	17-7	6
7	Christina Inofre	Owner	Nursing	1.00%	See Attached	1.2	3%	Alloc. Salary	3,238	10-07	7
8	Cynthia Meystel	Relative	Clerical		See Attached	0.1	3%	Alloc. Salary	535	21-7	8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts anticipated to be considered allowable by the IL. Dept. of HFS.										11
12											12
13	TOTAL								\$ 19,650		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center

0051102 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center

0051102

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	AVAIL. BED DAYS	806,222	20	\$ 15,532	\$ 23,725	\$ 457	1	
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	806,222	20	27,235	10,706	23,725	801	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	806,222	20	2,325		23,725	68	3
4	17	ADMINISTRATIVE	AVAIL. BED DAYS	806,222	20	368,628	368,628	23,725	10,848	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	806,222	20	66,554		23,725	1,959	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	806,222	20	10,341		23,725	304	6
7	21	CLERICAL & GENERAL	AVAIL. BED DAYS	806,222	20	1,161,730	1,062,779	23,725	34,187	7
8	24	SEMINARS	AVAIL. BED DAYS	806,222	20	4,271		23,725	126	8
9	25	AUTO AND TRAVEL	AVAIL. BED DAYS	806,222	20	39,751		23,725	1,170	9
10	26	INSURANCE	AVAIL. BED DAYS	806,222	20	20,417		23,725	601	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	806,222	20	310,817		23,725	9,147	11
12	30	DEPRECIATION	AVAIL. BED DAYS	806,222	20	24,916		23,725	733	12
13	32	INTEREST	AVAIL. BED DAYS	806,222	20	20,530		23,725	604	13
14	33	REAL ESTATE TAX	AVAIL. BED DAYS	806,222	20	-		23,725		14
15	34	RENT	AVAIL. BED DAYS	806,222	20	180,000		23,725	5,297	15
16	35	AUTO RENTAL	AVAIL. BED DAYS	806,222	20	26,797		23,725	789	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,279,844	\$ 1,442,113	\$	67,091	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center

0051102

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY	AVAIL. BED DAYS	806,222	20	\$ 165,484	\$ 152,992	23,725	\$ 4,870	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	806,222	20	27,395		23,725	806	2
3	10	NURSING SALARY	AVAIL. BED DAYS	806,222	20	639,288	639,288	23,725	18,813	3
4	14	PROGRAM TRANSPORTATION	AVAIL. BED DAYS	806,222	20	39,307		23,725	1,157	4
5	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	806,222	20	88,801		23,725	2,613	5
6	17	ADMINISTRATIVE	AVAIL. BED DAYS	806,222	20	354,711	354,711	23,725	10,438	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	806,222	20	19,212		23,725	565	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	806,222	20	34,122		23,725	1,004	8
9	21	CLERICAL & GENERAL	AVAIL. BED DAYS	806,222	20	270,517	258,772	23,725	7,961	9
10	24	SEMINARS	AVAIL. BED DAYS	806,222	20	8,935		23,725	263	10
11	25	AUTO AND TRAVEL	AVAIL. BED DAYS	806,222	20	34,250		23,725	1,008	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	806,222	20	113,873		23,725	3,351	12
13	26	INSURANCE	AVAIL. BED DAYS	806,222	20	4,192		23,725	123	13
14	35	AUTO RENTAL	AVAIL. BED DAYS	806,222	20	36,968		23,725	1,088	14
15	6	REPAIRS AND MAINTENANCE	AVAIL. BED DAYS	806,222	20	72,622	72,622	23,725	2,137	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,909,677	\$ 1,478,385		\$ 56,197	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center

0051102 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	AVAIL. BED DAYS	806,222	20	\$ 4,605	\$ 37,960	\$ 136	1
2	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	806,222	20	250	37,960	7	2
3	21	OFFICE EXPENSE	AVAIL. BED DAYS	806,222	20	2,000	37,960	59	3
4	30	DEPRECIATION	AVAIL. BED DAYS	806,222	20	51,991	37,960	1,530	4
5	32	INTEREST EXPENSE	AVAIL. BED DAYS	806,222	20	48,653	37,960	1,432	5
6	33	REAL ESTATE TAXES	AVAIL. BED DAYS	806,222	20	61,377	37,960	1,806	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 168,876	\$	\$ 4,970	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center

0051102 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization ProPay HR LLC
 Street Address 2201 W. Main St
 City / State / Zip Code Evanston, IL 60202
 Phone Number (847) 905-3268
 Fax Number ()

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Payroll Services	Direct		\$	\$		\$ 6,751	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				\$	\$		\$ 6,751	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center

0051102 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center

0051102 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center

0051102 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center

0051102 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center

0051102 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Litchfield Care Center

0051102

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																						
1. Real Estate Tax accrual used on 2012 report.		\$	<u>22,440</u>		1																			
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<u>23,941</u>		2																			
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>1,501</u>		3																			
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>22,135</u>		4																			
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5																			
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6																			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>23,636</u>		7																			
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:	2008	_____	8	<table border="1" style="width: 100%;"> <tr> <td colspan="3" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2012</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2012	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR BHF USE ONLY																								
13	FROM R. E. TAX STATEMENT FOR 2012	\$	13																					
14	PLUS APPEAL COST FROM LINE 5	\$	14																					
15	LESS REFUND FROM LINE 6	\$	15																					
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																					
	2009	_____	9																					
	2010	<u>21,891</u>	10																					
	2011	<u>22,440</u>	11																					
	2012	<u>22,135</u>	12																					
2013 Accrual = 2012 Tax Bill																								
8131 N Monticello Allocation = \$1,806																								

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2010</u>	<u>\$ 8,241</u>	<u>1</u>
2	<u>Allocated from 8131 N Monticello</u>		<u>2010</u>	<u>2,619</u>	<u>2</u>
3	TOTALS			\$ 10,860	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center

0051102

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	65		2010	1971	\$ 666,776	\$ 49,182	35	\$ 19,051	\$ (30,131)	\$ 63,503	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68			32,742	1,674	1,201	(473)	3,881	68
69				40,175		(40,175)		69
70			\$ 699,518	\$ 91,031		\$ 20,252	\$ (70,779)	\$ 67,384 70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 699,518	\$ 91,031		\$ 20,252	\$ (70,779)	\$ 67,384	1
2	Dry Pipe Valve	2011	3,825		20	383	383	1,148	2
3	New Canopy	2011	5,250		20	525	525	1,356	3
4	Camera System	2011	6,074		20	1,215	1,215	3,341	4
5	New Roof Including Soffitt, Fascia And Gutter System	2011	59,675		20	2,984	2,984	8,703	5
6	Remove & Replace Windows & Screens	2011	65,664		20	3,283	3,283	9,576	6
7	Remove Rooftop A/C Unit, Replace With Ground Units	2011	19,554		20	978	978	2,852	7
8	Drywall Laundry Room, Break Room & Closet Ceilings, Behind O	2011	5,000		20	250	250	729	8
9	4 Outside Outlets, 6 Outside Lights, Remove Old Antenna	2011	2,940		20	147	147	429	9
10	New Landscaping, 17 Ft. Fence, Flagpole	2011	6,350		20	318	318	926	10
11	Remove And Replace Concrete At Front Door	2011	5,500		20	275	275	802	11
12	Garage - New Siding, Roof & Door	2011	4,200		20	210	210	613	12
13	Office - New P-Tech Units, Drywall, Wiring & Siding	2011	3,530		20	177	177	515	13
14	Cabinets & Countertops - Break Room, Nurse Station, Mop Room	2011	5,500		20	275	275	802	14
15	West Side - Remove & Replace Concrete	2011	4,100		20	205	205	598	15
16	Electrical For Ight Fixtures And Thermoplastic Insulation	2012	21,095		20	2,110	2,110	3,516	16
17	Modify Doors, & Dining Room Cabinets, Cleaned Drains	2012	15,145		20	1,515	1,515	3,029	17
18	Parking Lot	2012	41,734		20	2,784	2,784	4,173	18
19	Replaced 58 Sprinkler Heads	2013	3,250		20	325	325	325	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 977,904	\$ 91,031		\$ 38,207	\$ (52,824)	\$ 110,815	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Litchfield Care Center

0051102

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 977,904	\$ 91,031		\$ 38,207	\$ (52,824)	\$ 110,815	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 977,904	\$ 91,031		\$ 38,207	\$ (52,824)	\$ 110,815	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Litchfield Care Center

0051102

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 977,904	\$ 91,031		\$ 38,207	\$ (52,824)	\$ 110,815	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 977,904	\$ 91,031		\$ 38,207	\$ (52,824)	\$ 110,815	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Litchfield Care Center

0051102

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 977,904	\$ 91,031		\$ 38,207	\$ (52,824)	\$ 110,815	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 977,904	\$ 91,031		\$ 38,207	\$ (52,824)	\$ 110,815	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Litchfield Care Center

0051102

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 8131 N Monticello	2010	20,350	605	20	522	(83)	1,804	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from YAM Management	2010	969	97	20	97		317	9
10	Allocated from YAM Management	2012	612	41	20	41		62	10
11	Allocated from YAM Management	2013	109	6	20	6		6	11
12									12
13	Allocated from 8131 N Monticello	2010	9,116	912	20	456	(456)	1,613	13
14	Allocated from 8131 N Monticello	2013	1,586	13	20	79	66	79	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Litchfield Care Center

0051102

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 32,742	\$ 1,674		\$ 1,201	\$ (473)	\$ 3,881	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 227,501	\$ 308	\$ 26,832	\$ 26,524	10	\$ 73,098	71
72	Current Year Purchases	7,456	68	577	509	10	577	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 234,957	\$ 376	\$ 27,409	\$ 27,033		\$ 73,675	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2007 Ford E350- Purchased New	2011	\$ 16,615	\$	\$ 2,498	\$ 2,498	5	\$ 7,457	76
77		Alloc from YAM Management	2009	1,001	213	213		5	503	77
78										78
79										79
80	TOTALS			\$ 17,616	\$ 213	\$ 2,711	\$ 2,498		\$ 7,960	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)	\$ 1,241,337	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 91,620	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 68,327	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (23,293)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 192,450	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 5,772 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		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 prescripts													9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify): See Supplemental															13
14	TOTAL			\$		\$		\$								14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center# 0051102Report Period Beginning: 01/01/13

Ending:

12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 255	\$ 5,886	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	271,138	273,962	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,916	44,916	6
7	Other Prepaid Expenses	9,212	9,212	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	465	465	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 325,986	\$ 334,441	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		182,918	13
14	Buildings, at Historical Cost		330,516	14
15	Leasehold Improvements, at Historical Cost	274,749	304,164	15
16	Equipment, at Historical Cost	74,327	263,152	16
17	Accumulated Depreciation (book methods)	(103,652)	(267,237)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	771,088	820,128	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,016,512	\$ 1,633,641	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,342,498	\$ 1,968,082	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 165,222	\$ 165,221	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	192,892	192,892	29
30	Accrued Salaries Payable	105,012	105,012	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,076	4,076	31
32	Accrued Real Estate Taxes(Sch.IX-B)		22,135	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 467,202	\$ 489,336	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		870,440	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	872,459	1,203,219	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 872,459	\$ 2,073,659	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,339,661	\$ 2,562,995	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,837	\$ (594,913)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,342,498	\$ 1,968,082	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 36,450	1
2	Restatements (describe):		2
3	Bad Debts	5,000	3
4	Rounding	(3)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 41,447	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(33,610)	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	(5,000)	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)	\$ (38,610)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,837	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 3,092,209		1
2	Discounts and Allowances for all Levels	(928,038)		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,164,171		3
B. Ancillary Revenue				
4	Day Care			4
5	Other Care for Outpatients			5
6	Therapy			6
7	Oxygen			7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$		8
C. Other Operating Revenue				
9	Payments for Education			9
10	Other Government Grants			10
11	CNA Training Reimbursements			11
12	Gift and Coffee Shop			12
13	Barber and Beauty Care			13
14	Non-Patient Meals			14
15	Telephone, Television and Radio			15
16	Rental of Facility Space			16
17	Sale of Drugs			17
18	Sale of Supplies to Non-Patients			18
19	Laboratory			19
20	Radiology and X-Ray			20
21	Other Medical Services			21
22	Laundry			22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$		23
D. Non-Operating Revenue				
24	Contributions			24
25	Interest and Other Investment Income***			25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$		26
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)			27
28				28
28a				28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,164,171		30

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	495,524		31
32	Health Care	733,377		32
33	General Administration	517,088		33
B. Capital Expense				
34	Ownership	255,900		34
C. Ancillary Expense				
35	Special Cost Centers	58,341		35
36	Provider Participation Fee	137,551		36
D. Other Expenses (specify):				
37				37
38				38
39				39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,197,781		40
41	Income before Income Taxes (line 30 minus line 40)**	(33,610)		41
42	Income Taxes			42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (33,610)		43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,060,206	44
45	Private Pay - Net Inpatient Revenue	103,965	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,164,171	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 Litchfield Care Center

0051102

Report Period Beginning: 01/01/13

Ending: 12/31/13

12/31/13

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,808	2,160	\$ 67,031	\$ 31.03	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,289	3,634	86,277	23.74	3
4	Licensed Practical Nurses	6,676	7,121	107,752	15.13	4
5	CNAs & Orderlies	21,357	23,017	249,473	10.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,021	2,272	33,436	14.72	9
10	Activity Assistants					10
11	Social Service Workers	3,584	3,864	74,042	19.16	11
12	Dietician					12
13	Food Service Supervisor	1,884	2,106	30,120	14.30	13
14	Head Cook	2,532	2,915	33,896	11.63	14
15	Cook Helpers/Assistants	4,657	4,973	52,566	10.57	15
16	Dishwashers					16
17	Maintenance Workers	3,783	4,413	60,400	13.69	17
18	Housekeepers	4,803	5,458	62,325	11.42	18
19	Laundry	3,333	3,866	41,634	10.77	19
20	Administrator	1,960	2,080	60,600	29.13	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,666	4,018	46,643	11.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,878	2,062	53,404	25.90	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	67,231	73,959	\$ 1,059,599 *	\$ 14.33	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	63	\$ 3,655	01-03	35
36	Medical Director	Monthly	6,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	273	15,300	10-03	38
39	Pharmacist Consultant	43	2,623	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	49	2,714	11-03	44
45	Social Service Consultant	41	2,041	12-03	45
46	Other(specify)				46
47	Psychiartric M.D.	Monthly	5,500	10-03	47
48					48
49	TOTAL (lines 35 - 48)	469	\$ 37,833		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center

0051102

Report Period Beginning: 01/01/13

Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Barbara Lowry	Administrator	0	\$ 60,600	Workers' Compensation Insurance	\$ 12,667	IDPH License Fee	\$ 3,980		
				Unemployment Compensation Insurance	26,677	Advertising: Employee Recruitment	185		
				FICA Taxes	80,371	Health Care Worker Background Check			
				Employee Health Insurance	8,310	(Indicate # of checks performed <u>77</u>)	772		
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	3,378		
				Other Employee Benefits	1,078	Licenses & Permits	471		
						Allocated from YAM Consulting	1,004		
						Allocated from YAM Management	304		
						See Supplemental Schedule	7		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 60,600	TOTAL (agree to Schedule V, line 22, col.8)		\$ 129,103	TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other									
Description			Amount						
YAM Consulting - Administrative Consulting			\$ 38,000						
Management Fees - Yosef Meystel			2,188						
Management Fees - David Berkowitz			2,841						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 43,029	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description			Description		
Vendor/Payee	Type		Amount		Line #	Amount		Amount	
FR&R	Accounting		\$ 22,943					Out-of-State Travel	
Centralia	Accounting		1,250					\$	
YAM Management	Bookkeeping/Accounting		74,675						
YAM Consulting	Data Processing		3,290					In-State Travel	
Pro Payroll Solutions	Payroll Services		7,760						
E-Health Data Solutions	MDS Software		1,800						
Galaxy Hosted Software Inc	Clinical Software		12,488						
Wescom Solutions Inc	E.H.R. Software		5,740					Seminar Expense	
YAM Management	Data Processing		1,455					1,886	
YAM Management	Legal		109					Allocated from YAM Consulting	
Gutnicki LLP	Legal		105					263	
See Supplemental Schedule			3,722					Allocated from YAM Management	
								126	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 135,337	TOTAL			\$	Entertainment Expense (agree to Sch. V, line 24, col. 8)	
								TOTAL	
								\$ 2,275	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Care Center# 0051102

Report Period Beginning:

01/01/13

Ending:

12/31/13**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$6,187
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 50 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 137,551
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. \$ None 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? N/A
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.