FOR BHF USE

LL1

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

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0048454

Facility Name: Evanston Nursing & Rehab Center

Address: 1300 Oak Avenue (Number) Evanston (City) 60201 (Zip Code)

County: Cook

Telephone Number: (847) 869-1300 **Fax #** (847) 869-1378

HFS ID Number:

Date of Initial License for Current Owners: 09/01/2006

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	57	Skilled (SNF)	57	20,805	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	57	TOTALS	57	20,805	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,265	927	2,753	18,945	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,265	927	2,753	18,945	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.06%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 09/08/2006

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/08/2006 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 57 and days of care provided 2,019

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	128,196	8,097	10,918	147,211		147,211	(10,918)	136,293			1
2	Food Purchase		89,660		89,660	(20,484)	69,176	(44)	69,132			2
3	Housekeeping	53,004	6,480		59,484		59,484		59,484			3
4	Laundry	17,675	3,897		21,572		21,572		21,572			4
5	Heat and Other Utilities			53,821	53,821		53,821	(3,055)	50,766			5
6	Maintenance	39,194	5,548	48,444	93,186		93,186	11,129	104,315			6
7	Other (specify):*							786	786			7
8	TOTAL General Services	238,069	113,682	113,183	464,934	(20,484)	444,450	(2,102)	442,349			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	904,691	52,456	13,873	971,020		971,020	7,836	978,856			10
10a	Therapy											10a
11	Activities	39,595	3,561	1,569	44,725		44,725		44,725			11
12	Social Services	37,038		490	37,528		37,528	104	37,632			12
13	CNA Training											13
14	Program Transportation			1,264	1,264		1,264	1,156	2,420			14
15	Other (specify):*							2,248	2,248			15
16	TOTAL Health Care and Programs	981,324	56,017	29,196	1,066,537		1,066,537	11,344	1,077,881			16
	C. General Administration											
17	Administrative	79,155		12,600	91,755		91,755	7,229	98,984			17
18	Directors Fees											18
19	Professional Services			128,614	128,614	(5,931)	122,683	(83,580)	39,104			19
20	Dues, Fees, Subscriptions & Promotions			19,090	19,090		19,090	(7,859)	11,231			20
21	Clerical & General Office Expenses	24,553	52	81,723	106,328		106,328	(19,793)	86,535			21
22	Employee Benefits & Payroll Taxes			212,501	212,501	20,484	232,985		232,985			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,270	1,270		1,270	531	1,801			24
25	Other Admin. Staff Transportation			115	115		115	856	971			25
26	Insurance-Prop.Liab.Malpractice			78,860	78,860		78,860	706	79,566			26
27	Other (specify):*							7,879	7,879			27
28	TOTAL General Administration	103,708	52	534,773	638,533	14,553	653,086	(94,031)	559,055			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,323,101	169,751	677,152	2,170,004	(5,931)	2,164,073	(84,788)	2,079,285			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 Evanston Nursing & Rehab Center #0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			105,520	105,520		105,520	21,147	126,667			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,573	24,573		24,573	172,571	197,144			32
33	Real Estate Taxes			42,357	42,357	5,931	48,288	1,127	49,415			33
34	Rent-Facility & Grounds			250,000	250,000		250,000	(249,041)	959			34
35	Rent-Equipment & Vehicles			4,163	4,163		4,163	2,645	6,808			35
36	Other (specify):*			58,667	58,667		58,667		58,667			36
37	**TOTAL Ownership**			485,280	485,280	5,931	491,211	(51,552)	439,659			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		62,862	280,066	342,928		342,928		342,928			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			31,208	31,208		31,208		31,208			42
43	Other (specify):*			110,055	110,055		110,055	(110,055)				43
44	**TOTAL Special Cost Centers**		62,862	421,329	484,191		484,191	(110,055)	374,136			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,323,101	232,613	1,583,761	3,139,475	(0)	3,139,475	(246,394)	2,893,081			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

***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 Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,657)	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	(24,556)	30		9
10	Interest and Other Investment Income	(60)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(44)	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	(4,441)	21		19
20	Contributions	(3,900)	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	(40,666)	21		24
25	Fund Raising, Advertising and Promotional	(2,057)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,994)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(117,251)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (201,626)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(44,768)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (44,768)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (246,394)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Evanston Nursing & Rehab Center

ID# 0048454

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	COPE Dues	$ (2,127)	20	1
2	Bank Charges	(7,098)	21	2
3	Marketing	(1,482)	43	3
4	Out of Period Professional Fees	(150)	19	4
5	Capitalized R&M	(8,071)	06	5
6	Additional R&M	12,923	06	6
7	Bldg Co. - Amortization	(21,818)	31	7
8	Bldg Co. - Bank Charges	(222)	21	8
9	Bldg Co. - Legal	(900)	19	9
10	Bldg Co. - Accounting	(5,500)	19	10
11	Bldg Co. - Licenses and Fees	(250)	20	11
12	Non-Allowable Legal	(83)	19	12
13	Non-Allowable Fees	(82,473)	43	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**	(117,251)		49

Evanston Nursing & Rehab Center

ID# 0048454

Report Period Beginning: 01/01/10

Ending: 12/31/10

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(10,918)								(10,918)	1
2	Food Purchase	(44)											(44)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(3,657)		602									(3,055)	5
6	Maintenance	4,852		1,483	4,768	26							11,129	6
7	Other (specify):*			233	553								786	7
8	**TOTAL General Services**	1,151		2,318	(5,597)	26							(2,102)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				7,836								7,836	10
10a	Therapy													10a
11	Activities													11
12	Social Services				104								104	12
13	CNA Training													13
14	Program Transportation				1,156								1,156	14
15	Other (specify):*				2,248								2,248	15
16	**TOTAL Health Care and Programs**				11,344								11,344	16
	C. General Administration													
17	Administrative			4,172	3,057								7,229	17
18	Directors Fees													18
19	Professional Services	(6,633)	6,400	(80,120)	(4,188)	961							(83,580)	19
20	Fees, Subscriptions & Promotions	(8,334)	250	148	27	50							(7,859)	20
21	Clerical & General Office Expenses	(57,421)	222	33,478	3,905	23							(19,793)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			179	352								531	24
25	Other Admin. Staff Transportation			749	107								856	25
26	Insurance-Prop.Liab.Malpractice			706									706	26
27	Other (specify):*			6,837	1,042								7,879	27
28	**TOTAL General Administration**	(72,388)	6,872	(33,851)	4,302	1,035							(94,031)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(71,237)	6,872	(31,533)	10,049	1,061							(84,788)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(24,556)	43,474	1,729	19	481							21,147	30
31	Amortization of Pre-Op. & Org.	(21,818)	21,818											31
32	Interest	(60)	170,293	12		2,326							172,571	32
33	Real Estate Taxes			1,070		56							1,127	33
34	Rent-Facility & Grounds		(223,000)	(20,759)		(5,282)							(249,041)	34
35	Rent-Equipment & Vehicles			646	1,999								2,645	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(46,434)	12,585	(17,303)	2,019	(2,418)							(51,552)	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):*	(83,955)			(26,100)								(110,055)	43
44	**TOTAL Special Cost Centers**	(83,955)			(26,100)								(110,055)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(201,626)	19,457	(48,835)	(14,032)	(1,358)							(246,394)	45

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		Evanston NRC Realty, LLC		Building Co.
				See Attached		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 225,000	Evanston NRC Realty, LLC	100.00%	$	$ (225,000)	1
2	V	33	Rental Income - R/E Taxes	42,357	Evanston NRC Realty, LLC	100.00%		(42,357)	2
3	V	32	Interest	24,977	Evanston NRC Realty, LLC	100.00%	195,270	170,293	3
4	V	31	Amortization		Evanston NRC Realty, LLC	100.00%	21,818	21,818	4
5	V	21	Bank Charges		Evanston NRC Realty, LLC	100.00%	222	222	5
6	V	30	Depreciation		Evanston NRC Realty, LLC	100.00%	43,474	43,474	6
7	V	19	Legal Fees		Evanston NRC Realty, LLC	100.00%	900	900	7
8	V	34	Rent		Evanston NRC Realty, LLC	100.00%	2,000	2,000	8
9	V	33	Real Estate Taxes		Evanston NRC Realty, LLC	100.00%	42,357	42,357	9
10	V	19	Accounting		Evanston NRC Realty, LLC	100.00%	5,500	5,500	10
11	V	20	Licenses and Fees		Evanston NRC Realty, LLC	100.00%	250	250	11
12	V								12
13	V								13
14	Total			$ 292,334			$ 311,791	$ * 19,457	14

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	YAM MANAGEMENT, LLC	100.00%	$ 602	$ 602	15
16	V	6	REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	1,483	1,483	16
17	V	7	EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	233	233	17
18	V	17	ADMIN. - RELATED		YAM MANAGEMENT, LLC	100.00%	2,957	2,957	18
19	V	17	ADMIN. - NON RELATED		YAM MANAGEMENT, LLC	100.00%	1,215	1,215	19
20	V	19	PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	2,680	2,680	20
21	V	20	FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	148	148	21
22	V	21	CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	33,478	33,478	22
23	V	24	SEMINARS		YAM MANAGEMENT, LLC	100.00%	179	179	23
24	V	25	AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	749	749	24
25	V	26	INSURANCE		YAM MANAGEMENT, LLC	100.00%	706	706	25
26	V	27	EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	6,837	6,837	26
27	V	30	DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	1,729	1,729	27
28	V	32	INTEREST		YAM MANAGEMENT, LLC	100.00%	12	12	28
29	V	33	REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%	1,070	1,070	29
30	V	34	RENT		YAM MANAGEMENT, LLC	100.00%	6,241	6,241	30
31	V	35	AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	372	372	31
32	V	35	EQUIPMENT RENTAL		YAM MANAGEMENT, LLC	100.00%	274	274	32
33	V								33
34	V								34
35	V	19	BOOKKEEPING FEES	46,800	YAM MANAGEMENT, LLC	100.00%		(46,800)	35
36	V	19	ACCOUNTING	36,000	YAM MANAGEMENT, LLC	100.00%		(36,000)	36
37	V	34	RENT	27,000	YAM MANAGEMENT, LLC	100.00%		(27,000)	37
38	V								38
39	Total			$ 109,800			$ 60,965	$ * (48,835)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	DIETARY	$	YAM CONSULTING, LLC	100.00%	$ 4,768	$ 4,768	15
16	V	7	EMP. BEN. GEN. SERV.		YAM CONSULTING, LLC	100.00%	553	553	16
17	V	10	NURSING SALARY		YAM CONSULTING, LLC	100.00%	17,926	17,926	17
18	V	12	SOCIAL SERVICES SALARY		YAM CONSULTING, LLC	100.00%	104	104	18
19	V	14	PROGRAM TRANSPORTATION		YAM CONSULTING, LLC	100.00%	1,156	1,156	19
20	V	15	EMP. BEN. HEALTHCARE		YAM CONSULTING, LLC	100.00%	2,248	2,248	20
21	V	17	ADMIN. - NON RELEATED		YAM CONSULTING, LLC	100.00%	3,657	3,657	21
22	V	19	PROFESSIONAL FEES		YAM CONSULTING, LLC	100.00%	92	92	22
23	V	20	FEES, SUBSCRIPTIONS		YAM CONSULTING, LLC	100.00%	27	27	23
24	V	21	CLERICAL & GENERAL		YAM CONSULTING, LLC	100.00%	3,905	3,905	24
25	V	24	SEMINARS		YAM CONSULTING, LLC	100.00%	352	352	25
26	V	25	AUTO AND TRAVEL		YAM CONSULTING, LLC	100.00%	107	107	26
27	V	27	EMP. BEN.-GEN. ADMIN.		YAM CONSULTING, LLC	100.00%	1,042	1,042	27
28	V	30	DEPRECIATION		YAM CONSULTING, LLC	100.00%	19	19	28
29	V	35	AUTO RENTAL		YAM CONSULTING, LLC	100.00%	1,999	1,999	29
30	V								30
31	V								31
32	V								32
33	V	01	DIETICIAN CONSULTING	10,918				(10,918)	33
34	V	10	RN CONSULTING	10,090				(10,090)	34
35	V	17	DIR. OF OPERATIONS CONSULT	600				(600)	35
36	V	19	DATA PROCESSING FEES	4,280				(4,280)	36
37	V	43	MARKETING	26,100				(26,100)	37
38	V								38
39	Total			$ 51,988			$ 37,956	$ * (14,032)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS & MAINTENANCE	$	8131 N. MONTICELLO, LLC	100.00%	$ 26	$ 26	15
16	V	19	PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		961	961	16
17	V	20	DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		50	50	17
18	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		23	23	18
19	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		481	481	19
20	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		2,326	2,326	20
21	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		1,126	1,126	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	5,282	8131 N. MONTICELLO, LLC			(5,282)	26
27	V	33	R/E	1,070				(1,070)	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			$ 6,352			$ 4,994	$ * (1,358)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Owner	Administrative	40.25%	See Attached	1.4	3.50%	Mgmt. Fees	$ 12,000	17-03	1
2	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.7	1.75%	Alloc. Salary	2,045	17-07	2
3	Joel Meystel	Relative	Administrative	0.00%	See Attached	0.7	3.50%	Alloc. Salary	912	17-07	3
4	Shimon Meystel	Relative	Clerical	0.00%	See Attached	1.4	3.50%	Alloc. Salary	484	21-07	4
5											5
6											6
7	Where Applicable, The Amounts Reported On This Page Have Been Adjusted From The Actual Costs To Reflect Only Amounts Anticipated To Be Considered Allowable										7
8	By The IL. Department of HFS										8
9											9
10											10
11											11
12											12
13								TOTAL	$ 15,441		13

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

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. BED DAYS	579,474	16	$ 16,764	$	20,805	$ 602	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	579,474	16	41,306	29,925	20,805	1,483	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	579,474	16	6,478		20,805	233	3
4	17	ADMIN. - RELATED	AVAIL. BED DAYS	579,474	16	82,362	82,362	20,805	2,957	4
5	17	ADMIN. - NON RELATED	AVAIL. BED DAYS	579,474	16	33,843	33,843	20,805	1,215	5
6	19	PROFESSIONAL FEES	AVAIL. BED DAYS	579,474	16	74,656		20,805	2,680	6
7	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	579,474	16	4,114		20,805	148	7
8	21	CLERICAL & GENERAL	AVAIL. BED DAYS	579,474	16	932,452	841,703	20,805	33,478	8
9	24	SEMINARS	AVAIL. BED DAYS	579,474	16	4,974		20,805	179	9
10	25	AUTO AND TRAVEL	AVAIL. BED DAYS	579,474	16	20,872		20,805	749	10
11	26	INSURANCE	AVAIL. BED DAYS	579,474	16	19,661		20,805	706	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	579,474	16	190,434		20,805	6,837	12
13	30	DEPRECIATION	AVAIL. BED DAYS	579,474	16	48,156		20,805	1,729	13
14	32	INTEREST	AVAIL. BED DAYS	579,474	16	331		20,805	12	14
15	33	REAL ESTATE TAX	AVAIL. BED DAYS	579,474	16	29,806		20,805	1,070	15
16	34	RENT	AVAIL. BED DAYS	579,474	16	173,825		20,805	6,241	16
17	35	AUTO RENTAL	AVAIL. BED DAYS	579,474	16	10,347		20,805	372	17
18	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	579,474	16	7,632		20,805	274	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,698,015	$ 987,832		$ 60,965	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	DIETARY	AVAIL. BED DAYS	579,474	16	$ 132,801	$ 123,648	20,805	$ 4,768	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	579,474	16	15,402		20,805	553	2
3	10	NURSING SALARY	AVAIL. BED DAYS	579,474	16	499,281	499,281	20,805	17,926	3
4	12	SOCIAL SERVICES SALARY	AVAIL. BED DAYS	579,474	16	2,888	2,888	20,805	104	4
5	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	579,474	16	32,206		20,805	1,156	5
6	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	579,474	16	62,625		20,805	2,248	6
7	17	ADMIN. - NON RELEATED	AVAIL. BED DAYS	579,474	16	101,866	101,866	20,805	3,657	7
8	19	PROFESSIONAL FEES	AVAIL. BED DAYS	579,474	16	2,550		20,805	92	8
9	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	579,474	16	755		20,805	27	9
10	21	CLERICAL & GENERAL	AVAIL. BED DAYS	579,474	16	108,757	86,009	20,805	3,905	10
11	24	SEMINARS	AVAIL. BED DAYS	579,474	16	9,816		20,805	352	11
12	25	AUTO AND TRAVEL	AVAIL. BED DAYS	579,474	16	2,967		20,805	107	12
13	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	579,474	16	29,022		20,805	1,042	13
14	30	DEPRECIATION	AVAIL. BED DAYS	579,474	16	539		20,805	19	14
15	35	AUTO RENTAL	AVAIL. BED DAYS	579,474	16	55,686		20,805	1,999	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,057,162	$ 813,692		$ 37,956	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	REPAIRS & MAINTENANCE	PATIENT DAYS	579,474	6	$ 732	$	20,805	$ 26	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	579,474	6	26,780		20,805	961	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	579,474	6	1,405		20,805	50	3
4	21	OFFICE EXPENSE	PATIENT DAYS	579,474	6	630		20,805	23	4
5	30	DEPRECIATION	PATIENT DAYS	579,474	6	13,389		20,805	481	5
6	32	INTEREST EXPENSE	PATIENT DAYS	579,474	6	64,796		20,805	2,326	6
7	33	REAL ESTATE TAXES	PATIENT DAYS	579,474	6	31,375		20,805	1,126	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					$ 139,107	$		$ 4,994	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bldg. Co - Mortgage Payable		X	Mortgage			$	$ 4,000,000			$ 195,270	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Lake Forest Bank & Trust Co.		X	Line of Credit				208,000			24,223	6
7	Insurance Policies		X								350	7
8	See Supplemental Schedule										2,338	8
9	TOTAL Facility Related						$	$ 4,208,000			$ 222,181	9
	B. Non-Facility Related*											
10	Interest Income		X								(60)	10
11	Bldg Co. Interest Income		X								(24,977)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (25,037)	14
15	TOTALS (line 9+line14)						$	$ 4,208,000			$ 197,144	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated From YAM Mgmt		X				$	$			$ 12	8
9	Allocated From 8131 N. Monticello		X								2,326	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										2,338	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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 2009 report.	$	105,000	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.)	$	74,796	2
3. Under or (over) accrual (line 2 minus line 1).	$	(30,204)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	73,689	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.**	$	5,931	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.	$	49,416	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005		8
2006	113,628	9
2007	100,729	10
2008	104,597	11
2009	73,669	12

2010 Accrual = 2009 R/E Tax
Allocated From 8131 N. Monticello = $1126

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Evanston Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048454

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-18-326-011-0000	Long Term Care Property	$ 73,668.51	$ 73,668.51
2.	10-23-325-045-0000	Allocated From Mgmt Co.	$ 30,331.21	$ 1,088.99
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 103,999.72	$ 74,757.50

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

IMPORTANT NOTICE

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

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

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

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

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Evanston Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048454

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,609 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			2008	$ 286,895	1
2					2
3	TOTALS			$ 286,895	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		1,644,650	19,606		46,990	27,384	83,777	67
68	Related Party Allocations (Pages 12H & 12I)		45,350	494		719	225	789	68
69	Financial Statement Depreciation			105,520			(105,520)		69
70	TOTAL (lines 4 thru 69)		$ 1,690,000	$ 125,620		$ 47,709	$ (77,911)	$ 84,566	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,690,000	$ 125,620		$ 47,709	$ (77,911)	$ 84,566	1
2	Carpeting	2007	4,156		20	416	416	1,628	2
3	Econocare	2007	7,185		20	479	479	1,677	3
4	Shower Room And Nurses Station	2007	25,410		20	2,541	2,541	8,047	4
5	Econocare - Railings	2007	8,221		20	411	411	1,336	5
6	Econocare - Wallcoverings	2007	12,716		20			12,716	6
7	Kitchen Floor, Shower Room And Plumbing	2008	5,550		20	555	555	1,619	7
8	2Nd Floor Outside Patio Work	2008	32,262		20	3,226	3,226	8,066	8
9	Electrical Work	2008	4,100		20	410	410	957	9
10	2Nd Floor Porch	2008	6,876		20	688	688	1,719	10
11	2Nd Floor Nurses Station	2008	14,300		20	1,430	1,430	3,694	11
12	Cornice, Cubicle Curtains, Bed Quilts	2008	7,865		20	787	787	1,835	12
13	Handrails, Bumpers, Wallcoverings, Etc	2008	25,009		20	2,501	2,501	5,627	13
14	Fireplace And Light Installation	2009	4,550		20	455	455	834	14
15	Window Treatments; Cubicle Curtains; Chair	2009	15,559		20	1,556	1,556	2,593	15
16	Flooring Sealant, Carpet Removal, New Hardwood Floor	2009	6,900		20	690	690	920	16
17	Ground Floor Washroom- Floor And Wall Tiles, Grab Bars	2009	4,425		20	443	443	664	17
18	1St & 2Nd Flr Bathrooms- Floor Tiles, Electrical, Paint	2009	17,200		20	1,720	1,720	2,150	18
19	New Elevator Equipment	2009	9,966		20	997	997	1,246	19
20	Acm Elevator	2010	4,415		20	221	221	221	20
21	Window Treatment	2010	3,104		20	621	621	621	21
22	Bathrooms - Fixtures, Tile, Flooring, Door, Paint, Lights	2010	16,000		20	800	800	800	22
23	Bathrooms - Fixtures, Tile, Flooring, Door, Paint, Lights	2010	4,000		20	200	200	200	23
24	Bathrooms - Fixtures, Tile, Flooring, Door, Paint, Lights	2010	4,000		20	200	200	200	24
25	Bathrooms - Fixtures, Tile, Flooring, Door, Paint, Lights	2010	4,000		20	183	183	183	25
26	Flooring Office	2010	3,121		20	572	572	572	26
27	Bathrooms - Fixtures, Tile, Flooring, Door, Paint, Lights, Plumbin	2010	5,256		20	197	197	197	27
28	Light Installation	2010	7,445		20	186	186	186	28
29	Living Room Tile	2010	9,854		20	164	164	164	29
30	Overbed Lighting	2010	3,632		20	363	363	363	30
31	Built-In Dresers, Cover Lights, Granite Tops, Locks & Installatior	2010	31,000		20	517	517	517	31
32	Repair And Paint Walls, Handrails	2010	3,420		20	71	71	71	32
33	Plumbing	2010	4,651		20	155	155	155	33
34	TOTAL (lines 1 thru 33)		$ 2,006,148	$ 125,620		$ 71,463	$ (54,157)	$ 146,343	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,006,148	$ 125,620		$ 71,463	$ (54,157)	$ 146,343	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		$ 2,006,148	$ 125,620		$ 71,463	$ (54,157)	$ 146,343	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,006,148	$ 125,620		$ 71,463	$ (54,157)	$ 146,343	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		$ 2,006,148	$ 125,620		$ 71,463	$ (54,157)	$ 146,343	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,006,148	$ 125,620		$ 71,463	$ (54,157)	$ 146,343	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
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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)		$ 2,006,148	$ 125,620		$ 71,463	$ (54,157)	$ 146,343	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3	Evanston NRC Realty, LLC	1961	1,644,650	19,606	35	46,990	27,384	83,777	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 Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$ 1,644,650	$ 19,606		$ 46,990	$ 27,384	$ 83,777	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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, LLC	2010	31,991	339	39	338	(1)	338	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From YAM Management, LLC	2007	768	2	20	38	36	120	9
10	Allocated From YAM Management, LLC	2008	53	1	20	2	1		10
11	Allocated From YAM Management, LLC	2009	233	3	20	10	7		11
12	Allocated From YAM Management, LLC	2010	1,183	7	20	32	25	32	12
13									13
14	Allocated From 8131 N. Monticello, LLC	2010	11,122	142	20	299	157	299	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 Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 45,350	$ 494		$ 719	$ 225	$ 789	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 393,704	$ 24,363	$ 49,794	$ 25,431	10	$ 135,740	71
72	Current Year Purchases	41,147	1,143	5,259	4,116	10	5,259	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 434,851	$ 25,506	$ 55,053	$ 29,547		$ 140,999	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated From YAM Mgmt.	2009	$ 848	$ 97	$ 151	$ 54	5	$ 495	76
77										77
78										78
79										79
80	TOTALS			$ 848	$ 97	$ 151	$ 54		$ 495	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)	$ 2,728,742	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 151,223	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 126,667	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (24,556)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 287,838	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] 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:		57		$			3
4	Additions							4
5	Allocated From YAM Mgmt, LLC				959			5
6								6
7	TOTAL		57		$ 959 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: [ ] YES [ ] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 4,438 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated From YAM Mgmt		$	$ 372	17
18	Allocated From YAM Consult			1,999	18
19					19
20					20
21	TOTAL		$	$ 2,371	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 85,815	$		$ 85,815	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			70,989			70,989	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			123,262			123,262	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				57,782		57,782	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						5,080		5,080	13
14	TOTAL			$		$ 280,066	$ 62,862		$ 342,928	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 9,028	$ 2,025,206	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	214,873	214,873	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,993	49,993	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	290,448	290,448	8
9	Other(specify): See Attached Schedule	94,384	919,657	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 658,726	$ 3,500,177	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		286,895	13
14	Buildings, at Historical Cost		764,650	14
15	Leasehold Improvements, at Historical Cost	282,183	282,183	15
16	Equipment, at Historical Cost	220,683	493,621	16
17	Accumulated Depreciation (book methods)	(179,488)	(449,140)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	821,333	847,404	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,144,711	$ 2,225,613	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,803,437	$ 5,725,790	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 200,861	$ 200,860	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,689	6,689	28
29	Short-Term Notes Payable	208,000	208,000	29
30	Accrued Salaries Payable	119,998	119,998	30
31	Accrued Taxes Payable (excluding real estate taxes)	41	41	31
32	Accrued Real Estate Taxes(Sch.IX-B)	73,689	73,689	32
33	Accrued Interest Payable	1,968	1,968	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	850,397	859,772	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,461,643	$ 1,471,017	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,000,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,000,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,461,643	$ 5,471,017	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 341,794	$ 254,773	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,803,437	$ 5,725,790	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 207,108	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 207,109	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	390,567	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	(255,882)	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)**	$ 134,685	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)**	$ 341,794	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,382,951	1
2	Discounts and Allowances for all Levels	(611,044)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,771,907	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	684,685	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 684,685	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	57,509	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,595	19
20	Radiology and X-Ray	340	20
21	Other Medical Services	9,946	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 73,390	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	60	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 60	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,530,042	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	464,934	31
32	Health Care	1,066,537	32
33	General Administration	638,533	33
	B. Capital Expense		
34	Ownership	485,280	34
	C. Ancillary Expense		
35	Special Cost Centers	452,983	35
36	Provider Participation Fee	31,208	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,139,475	40
41	**Income before Income Taxes (line 30 minus line 40)****	390,567	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 390,567	43

* **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. SEE ACCOUNTANTS' COMPILATION REPORT**

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,013	2,086	$ 88,896	$ 42.62	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,016	3,262	95,542	29.29	3
4	Licensed Practical Nurses	11,365	12,325	297,567	24.14	4
5	CNAs & Orderlies	29,428	31,549	348,286	11.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,464	3,962	39,595	9.99	10
11	Social Service Workers	1,813	2,086	37,038	17.76	11
12	Dietician					12
13	Food Service Supervisor	1,938	2,086	36,500	17.50	13
14	Head Cook	4,269	4,643	52,007	11.20	14
15	Cook Helpers/Assistants	4,322	4,653	39,689	8.53	15
16	Dishwashers					16
17	Maintenance Workers	2,567	2,829	39,194	13.85	17
18	Housekeepers	5,278	5,606	53,004	9.45	18
19	Laundry	1,582	1,891	17,675	9.35	19
20	Administrator	1,845	2,086	79,155	37.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,251	2,380	24,553	10.32	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	3,433	3,735	74,400	19.92	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	78,584	85,179	$ 1,323,101 *	$ 15.53	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	218	$ 10,918	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	164	11,540	10-03	38
39	Pharmacist Consultant	Monthly	2,333	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	31	1,569	11-03	44
45	Social Service Consultant	9	490	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	422	$ 38,850		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Heather Eisner	Administrator	0.00%	$ 79,155
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 79,155

B. Administrative - Other

Description	Amount
Management Fees - Yosef Meystel	$ 12,000
YAM Consulting, LLC - Administrative	600
TOTAL (agree to Schedule V, line 17, col. 3)	$ 12,600
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 16,140
YAM Management	Accounting/Bookkeeping	82,800
Personnel Planners	Unemployment Consulting	1,240
E-Health Data Solutions	Risk Management	4,208
See Attached	Legal	7,479
Skidelsky & Associates	R/E Tax Assessment	5,931
Adj. on 5a	Out of Period Prof. Fees	150
American Data	Data Processing	3,712
Health Data Systems	Data Processing	2,675
YAM Consulting	Data Processing	4,280
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 128,615

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 23,559
Unemployment Compensation Insurance	7,374
FICA Taxes	95,085
Employee Health Insurance	74,407
Employee Meals	20,484
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension Expense	11,291
Other Employee Benefits	494
Life Insurance	291
TOTAL (agree to Schedule V, line 22, col.8)	$ 232,985

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	2,310
(Indicate # of checks performed 231)	
Patient Background Checks	
Dues & Subscriptions	2,304
Licenses & Permits	6,392
Advertising & Promotion	2,057
See Supplemental Schedule	225
Less: Public Relations Expense	( )
Non-allowable advertising	(2,057)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,231

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,270
Allocated From YAM Management	179
Allocated From YAM Consulting	352
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,801

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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. **ILCLTC $2304**

(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. $ **592** Line **10-02**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? **X** YES ____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **31,208**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **20,484** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? ____
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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