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: 0048330

Facility Name: Highland Park Nursing & Rehab

Address: 50 Pleasant Avenue (Number) Highwood (City) 60040 (Zip Code)

County: Lake

Telephone Number: (847) 432-9142 **Fax #** (847) 432-4740

HFS ID Number:

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

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 Highland Park Nursing & Rehab # 0048330 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 08/03/10

	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	82	Skilled (SNF)	104	33,252	1
2		Skilled Pediatric (SNF/PED)			2
3	13	Intermediate (ICF)		2,782	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	95	TOTALS	104	36,034	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	3,233	1,242	2,891	7,366	8
9	SNF/PED					9
10	ICF	12,928	4,970	38	17,936	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,161	6,212	2,929	25,302	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.22%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 9/06/06

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/06/06 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 82 and days of care provided 2,891

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 Highland Park Nursing & Rehab # 0048330 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	155,053	19,371	24,269	198,693		198,693	(24,269)	174,424			1
2	Food Purchase		126,075		126,075	(20,294)	105,781	(310)	105,471			2
3	Housekeeping	98,977	15,230		114,207		114,207		114,207			3
4	Laundry	65,110	8,693		73,803		73,803		73,803			4
5	Heat and Other Utilities			101,894	101,894		101,894	1,042	102,936			5
6	Maintenance	42,151		71,043	113,194		113,194	23,224	136,418			6
7	Other (specify):*							1,361	1,361			7
8	TOTAL General Services	361,291	169,369	197,206	727,866	(20,294)	707,572	1,048	708,620			8
	B. Health Care and Programs											
9	Medical Director			32,500	32,500		32,500		32,500			9
10	Nursing and Medical Records	1,264,850	86,098	25,691	1,376,639		1,376,639	9,822	1,386,461			10
10a	Therapy	30,787			30,787		30,787		30,787			10a
11	Activities	42,428	3,768	2,400	48,596		48,596		48,596			11
12	Social Services	554		33,429	33,983		33,983	180	34,163			12
13	CNA Training											13
14	Program Transportation							2,003	2,003			14
15	Other (specify):*							3,894	3,894			15
16	TOTAL Health Care and Programs	1,338,619	89,866	94,020	1,522,505		1,522,505	15,900	1,538,405			16
	C. General Administration											
17	Administrative	79,907		15,200	95,107		95,107	12,360	107,467			17
18	Directors Fees											18
19	Professional Services			163,814	163,814		163,814	(105,651)	58,163			19
20	Dues, Fees, Subscriptions & Promotions			48,566	48,566		48,566	(37,777)	10,789			20
21	Clerical & General Office Expenses	98,947	745	93,358	193,050		193,050	(13,837)	179,213			21
22	Employee Benefits & Payroll Taxes			291,120	291,120	20,294	311,414		311,414			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,359	1,359		1,359	919	2,278			24
25	Other Admin. Staff Transportation			2,978	2,978		2,978	1,482	4,460			25
26	Insurance-Prop.Liab.Malpractice			77,780	77,780		77,780	3,533	81,313			26
27	Other (specify):*							13,647	13,647			27
28	TOTAL General Administration	178,854	745	694,175	873,774	20,294	894,068	(125,323)	768,745			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,878,764	259,980	985,401	3,124,145		3,124,145	(108,375)	3,015,770			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 Highland Park Nursing & Rehab #0048330 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			60,216	60,216		60,216	111,636	171,852			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,878	24,878		24,878	354,625	379,503			32
33	Real Estate Taxes			47,529	47,529		47,529	1,951	49,480			33
34	Rent-Facility & Grounds			403,500	403,500		403,500	(401,839)	1,661			34
35	Rent-Equipment & Vehicles			5,265	5,265		5,265	6,581	11,846			35
36	Other (specify):*											36
37	TOTAL Ownership			541,388	541,388		541,388	72,955	614,343			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		97,630	425,313	522,943		522,943		522,943			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,052	54,052		54,052		54,052			42
43	Other (specify):*			133,161	133,161		133,161	(133,161)	(0)			43
44	TOTAL Special Cost Centers		97,630	612,526	710,156		710,156	(133,161)	576,995			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,878,764	357,610	2,139,315	4,375,689		4,375,689	(168,581)	4,207,108			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Highland Park Nursing & Rehab # 0048330 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	(5,521)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,470)	30		9
10	Interest and Other Investment Income	(112)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(310)	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	(4,556)	21		19
20	Contributions	(6,750)	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	(45,179)	21		24
25	Fund Raising, Advertising and Promotional	(31,417)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,542)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(166,726)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (266,583)		$	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)	98,002		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 98,002		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (168,581)		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

Highland Park Nursing & Rehab

ID# 0048330

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Pharmacy - Veteran	$ (450)	10	1
2	Miscellaneous Revenue	(16,313)	21	2
3	Bank Charges	(6,710)	21	3
4	Marketing Fees	(12,211)	43	4
5	Bldg Company License & Fees	(1,534)	20	5
6	Additional R&M	17,872	06	6
7	Non-Allowable Fees	(98,000)	43	7
8	Non-Allowable Legal	(2,499)	19	8
9	Vending Income	(1,323)	21	9
10	Bank Charges - Bldg Co.	(199)	21	10
11	Other Prof Fees - Bldg Co.	(10,300)	19	11
12	Amortization - Bldg Co.	(35,060)	36	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(166,726)		49

Highland Park Nursing & Rehab

ID# 0048330

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 Highland Park Nursing & Rehab **#** 0048330 **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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary				(24,269)								(24,269)	1
2	Food Purchase	(310)											(310)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,042									1,042	5
6	Maintenance	12,351		2,569	8,258	46							23,224	6
7	Other (specify):*			403	958								1,361	7
8	**TOTAL General Services**	12,041		4,014	(15,053)	46							1,048	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(450)			10,272								9,822	10
10a	Therapy													10a
11	Activities													11
12	Social Services				180								180	12
13	CNA Training													13
14	Program Transportation				2,003								2,003	14
15	Other (specify):*				3,894								3,894	15
16	**TOTAL Health Care and Programs**	(450)			16,349								15,900	16
	C. General Administration													
17	Administrative			7,226	5,134								12,360	17
18	Directors Fees													18
19	Professional Services	(12,799)	10,300	(97,251)	(7,567)	1,665							(105,651)	19
20	Fees, Subscriptions & Promotions	(39,701)	1,534	256	47	87							(37,777)	20
21	Clerical & General Office Expenses	(78,822)	199	57,984	6,763	39							(13,837)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			309	610								919	24
25	Other Admin. Staff Transportation			1,298	185								1,482	25
26	Insurance-Prop.Liab.Malpractice		2,310	1,223									3,533	26
27	Other (specify):*			11,842	1,805								13,647	27
28	**TOTAL General Administration**	(131,321)	14,343	(17,113)	6,977	1,792							(125,323)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(119,729)	14,343	(13,099)	8,273	1,837							(108,375)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Highland Park Nursing & Rehab** **#** **0048330** **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	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**(to Sch V, col.7)**	
30	Depreciation	(1,470)	109,246	2,995	34	833							111,636	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(112)	350,687	21		4,029							354,625	32
33	Real Estate Taxes			1,853		98							1,951	33
34	Rent-Facility & Grounds		(380,000)	(12,691)		(9,148)							(401,839)	34
35	Rent-Equipment & Vehicles		2,000	1,118	3,463								6,581	35
36	Other (specify):*	(35,060)	35,060											36
37	**TOTAL Ownership**	(36,642)	116,993	(6,703)	3,496	(4,188)							72,955	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):*	(110,211)			(22,950)								(133,161)	43
44	**TOTAL Special Cost Centers**	(110,211)			(22,950)								(133,161)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(266,583)	131,336	(19,802)	(11,181)	(2,351)							(168,581)	45

Facility Name & ID Number Highland Park Nursing & Rehab # 0048330 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		Highland Park NRC Realty, LLC		Bldg. Company
				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	$ 380,000	Highland Park NRC Realty, LLC	100.00%	$	$ (380,000)	1
2	V	20	License & Fees		Highland Park NRC Realty, LLC		1,534	1,534	2
3	V	36	Amortization - Loan Fees		Highland Park NRC Realty, LLC		35,060	35,060	3
4	V	21	Bank Charges		Highland Park NRC Realty, LLC		199	199	4
5	V	30	Depreciation		Highland Park NRC Realty, LLC		109,246	109,246	5
6	V	32	Interest - Mortgage		Highland Park NRC Realty, LLC		202,686	202,686	6
7	V	32	Interest - Other		Highland Park NRC Realty, LLC		148,001	148,001	7
8	V	19	Other Professional Fees		Highland Park NRC Realty, LLC		10,300	10,300	8
9	V	26	Insurance		Highland Park NRC Realty, LLC		2,310	2,310	9
10	V	35	Rent Expense		Highland Park NRC Realty, LLC		2,000	2,000	10
11	V								11
12	V								12
13	V								13
14	Total			$ 380,000			$ 511,336	$ * 131,336	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Highland Park Nursing & Rehab # 0048330 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%	$ 1,042	$ 1,042	15
16	V	6	REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	2,569	2,569	16
17	V	7	EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	403	403	17
18	V	17	ADMIN. - RELATED		YAM MANAGEMENT, LLC	100.00%	5,122	5,122	18
19	V	17	ADMIN. - NON RELATED		YAM MANAGEMENT, LLC	100.00%	2,104	2,104	19
20	V	19	PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	4,642	4,642	20
21	V	20	FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	256	256	21
22	V	21	CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	57,984	57,984	22
23	V	24	SEMINARS		YAM MANAGEMENT, LLC	100.00%	309	309	23
24	V	25	AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	1,298	1,298	24
25	V	26	INSURANCE		YAM MANAGEMENT, LLC	100.00%	1,223	1,223	25
26	V	27	EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	11,842	11,842	26
27	V	30	DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	2,995	2,995	27
28	V	32	INTEREST		YAM MANAGEMENT, LLC	100.00%	21	21	28
29	V	33	REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%	1,853	1,853	29
30	V	34	RENT		YAM MANAGEMENT, LLC	100.00%	10,809	10,809	30
31	V	35	AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	643	643	31
32	V	35	EQUIPMENT RENTAL		YAM MANAGEMENT, LLC	100.00%	475	475	32
33	V								33
34	V								34
35	V	19	BOOKKEEPING FEES	101,871	YAM MANAGEMENT, LLC	100.00%		(101,871)	35
36	V	19	DATA PROCESSING	22	YAM MANAGEMENT, LLC	100.00%		(22)	36
37	V	34	RENT	23,500	YAM MANAGEMENT, LLC	100.00%		(23,500)	37
38	V								38
39	Total			$ 125,393			$ 105,591	$ * (19,802)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Highland Park Nursing & Rehab # 0048330 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%	$ 8,258	$ 8,258	15
16	V	7	EMP. BEN. GEN. SERV.		YAM CONSULTING, LLC	100.00%	958	958	16
17	V	10	NURSING SALARY		YAM CONSULTING, LLC	100.00%	31,047	31,047	17
18	V	12	SOCIAL SERVICES SALARY		YAM CONSULTING, LLC	100.00%	180	180	18
19	V	14	PROGRAM TRANSPORTATION		YAM CONSULTING, LLC	100.00%	2,003	2,003	19
20	V	15	EMP. BEN. HEALTHCARE		YAM CONSULTING, LLC	100.00%	3,894	3,894	20
21	V	17	ADMIN. - NON RELEATED		YAM CONSULTING, LLC	100.00%	6,334	6,334	21
22	V	19	PROFESSIONAL FEES		YAM CONSULTING, LLC	100.00%	159	159	22
23	V	20	FEES, SUBSCRIPTIONS		YAM CONSULTING, LLC	100.00%	47	47	23
24	V	21	CLERICAL & GENERAL		YAM CONSULTING, LLC	100.00%	6,763	6,763	24
25	V	24	SEMINARS		YAM CONSULTING, LLC	100.00%	610	610	25
26	V	25	AUTO AND TRAVEL		YAM CONSULTING, LLC	100.00%	185	185	26
27	V	27	EMP. BEN.-GEN. ADMIN.		YAM CONSULTING, LLC	100.00%	1,805	1,805	27
28	V	30	DEPRECIATION		YAM CONSULTING, LLC	100.00%	34	34	28
29	V	35	AUTO RENTAL		YAM CONSULTING, LLC	100.00%	3,463	3,463	29
30	V								30
31	V								31
32	V	1	DIETARY CONSULTING	24,269				(24,269)	32
33	V	10	NURSING CONSULTING	20,775				(20,775)	33
34	V	17	ADMIN. CONSULTING	1,200				(1,200)	34
35	V	43	MARKETING	22,950				(22,950)	35
36	V	19	DATA PROCESSING FEES	7,726				(7,726)	36
37	V								37
38	V								38
39	Total			$ 76,920			$ 65,739	$ * (11,181)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Highland Park Nursing & Rehab # 0048330 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%	$ 46	$ 46	15
16	V	19	PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		1,665	1,665	16
17	V	20	DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		87	87	17
18	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		39	39	18
19	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		833	833	19
20	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		4,029	4,029	20
21	V	33	REAL ESTATE TAXES	1,853	8131 N. MONTICELLO, LLC		1,951	98	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	9,148	8131 N. MONTICELLO, LLC			(9,148)	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			$ 11,001			$ 8,650	$ * (2,351)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Highland Park Nursing & Rehab # 0048330 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 Highland Park Nursing & Rehab # 0048330 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Highland Park Nursing & Rehab # 0048330 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 Highland Park Nursing & Rehab # 0048330 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Highland Park Nursing & Rehab # 0048330 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Highland Park Nursing & Rehab # 0048330 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Highland Park Nursing & Rehab # 0048330 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	2.5	6%	Mgmt. Fees	$ 14,000	17-03	1
2	Jay Meystel	Relative	Administrative	0%	See Attached	1.2	3%	Alloc. Salary	3,542	17-07	2
3	Joel Meystel	Relative	Administrative	0%	See Attached	1.2	6%	Alloc. Salary	1,579	17-07	3
4	Shimon Meystel	Relative	Clerical	0%	See Attached	2.5	6%	Alloc. Salary	839	21-01	4
5											5
6											6
7	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect										7
8	only amounts anticipated to be considered allowable by the Il. Dept of HFS.										8
9											9
10											10
11											11
12											12
13								TOTAL	$ 19,960		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 Highland Park Nursing & Rehab # 0048330 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 Highland Park Nursing & Rehab # 0048330 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	$	36,034	$ 1,042	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	579,474	16	41,306	29,925	36,034	2,569	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	579,474	16	6,478		36,034	403	3
4	17	ADMIN. - RELATED	AVAIL. BED DAYS	579,474	16	82,362	82,362	36,034	5,122	4
5	17	ADMIN. - NON RELATED	AVAIL. BED DAYS	579,474	16	33,843	33,843	36,034	2,104	5
6	19	PROFESSIONAL FEES	AVAIL. BED DAYS	579,474	16	74,656		36,034	4,642	6
7	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	579,474	16	4,114		36,034	256	7
8	21	CLERICAL & GENERAL	AVAIL. BED DAYS	579,474	16	932,452	841,703	36,034	57,984	8
9	24	SEMINARS	AVAIL. BED DAYS	579,474	16	4,974		36,034	309	9
10	25	AUTO AND TRAVEL	AVAIL. BED DAYS	579,474	16	20,872		36,034	1,298	10
11	26	INSURANCE	AVAIL. BED DAYS	579,474	16	19,661		36,034	1,223	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	579,474	16	190,434		36,034	11,842	12
13	30	DEPRECIATION	AVAIL. BED DAYS	579,474	16	48,156		36,034	2,995	13
14	32	INTEREST	AVAIL. BED DAYS	579,474	16	331		36,034	21	14
15	33	REAL ESTATE TAX	AVAIL. BED DAYS	579,474	16	29,806		36,034	1,853	15
16	34	RENT	AVAIL. BED DAYS	579,474	16	173,825		36,034	10,809	16
17	35	AUTO RENTAL	AVAIL. BED DAYS	579,474	16	10,347		36,034	643	17
18	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	579,474	16	7,632		36,034	475	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,698,015	$ 987,832		$ 105,591	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Highland Park Nursing & Rehab # 0048330 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	36,034	$ 8,258	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	579,474	16	15,402		36,034	958	2
3	10	NURSING SALARY	AVAIL. BED DAYS	579,474	16	499,281	499,281	36,034	31,047	3
4	12	SOCIAL SERVICES SALARY	AVAIL. BED DAYS	579,474	16	2,888	2,888	36,034	180	4
5	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	579,474	16	32,206		36,034	2,003	5
6	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	579,474	16	62,625		36,034	3,894	6
7	17	ADMIN. - NON RELEATED	AVAIL. BED DAYS	579,474	16	101,866	101,866	36,034	6,334	7
8	19	PROFESSIONAL FEES	AVAIL. BED DAYS	579,474	16	2,550		36,034	159	8
9	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	579,474	16	755		36,034	47	9
10	21	CLERICAL & GENERAL	AVAIL. BED DAYS	579,474	16	108,757	86,009	36,034	6,763	10
11	24	SEMINARS	AVAIL. BED DAYS	579,474	16	9,816		36,034	610	11
12	25	AUTO AND TRAVEL	AVAIL. BED DAYS	579,474	16	2,967		36,034	185	12
13	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	579,474	16	29,022		36,034	1,805	13
14	30	DEPRECIATION	AVAIL. BED DAYS	579,474	16	539		36,034	34	14
15	35	AUTO RENTAL	AVAIL. BED DAYS	579,474	16	55,686		36,034	3,463	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		$ 65,739	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Highland Park Nursing & Rehab # 0048330 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	16	$ 732	$	36,034	$ 46	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	579,474	16	26,780		36,034	1,665	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	579,474	16	1,405		36,034	87	3
4	21	OFFICE EXPENSE	PATIENT DAYS	579,474	16	630		36,034	39	4
5	30	DEPRECIATION	PATIENT DAYS	579,474	16	13,389		36,034	833	5
6	32	INTEREST EXPENSE	PATIENT DAYS	579,474	16	64,796		36,034	4,029	6
7	33	REAL ESTATE TAXES	PATIENT DAYS	579,474	16	31,375		36,034	1,951	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	$		$ 8,650	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Highland Park Nursing & Rehab # 0048330 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 Highland Park Nursing & Rehab # 0048330 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 Highland Park Nursing & Rehab # 0048330 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 Highland Park Nursing & Rehab # 0048330 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 Highland Park Nursing & Rehab # 0048330 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 Highland Park Nursing & Rehab # 0048330 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 Highland Park Nursing & Rehab # 0048330 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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Lake Forest Bank & Trust		X	Mortgage			$	$ 2,837,266	9/08/11	7.4200	$ 202,686	1
2	Lake Forest Bank & Trust		X	Construction Loan				6,461,232			148,001	2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Lake Forest Bank & Trust		X	Line of Credit				535,000			23,960	6
7	GMAC		X	Loan Payable				30,783			918	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 9,864,281			$ 375,564	9
	B. Non-Facility Related*											
10	Interest Income		X								(112)	10
11	YAM Management Allocation	X									21	11
12	8131 N. Monticello Allocation	X									4,029	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ 3,938	14
15	TOTALS (line 9+line14)						$	$ 9,864,281			$ 379,503	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 Highland Park Nursing & Rehab # 0048330 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							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Highland Park Nursing & Rehab # 0048330 **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.	$ 48,000	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.)	$ 49,480	2
3. Under or (over) accrual (line 2 minus line 1).	$ 1,480	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 48,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 49,480	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005		8
2006	43,118	9
2007	45,964	10
2008	48,603	11
2009	47,529	12

2010 Accrual = 2009 Tax (Rounded)
Allocation from 8131 N. Monticello: $1,951

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 Highland Park Nursing & Rehab COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0048330

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.	16-15-427-002	Long Term Care Property	$ 47,528.96	$ 47,528.96
2.	Allocated from 8131 N. Monticello	Home Office Allocation	$ 30,331.21	$ 1,886.12
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 77,860.17	$ 49,415.08

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 Highland Park Nursing & Rehab COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0048330

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 Highland Park Nursing & Rehab # 0048330 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,802 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

D. Does the Operating Entity? [X] (a) Own the Equipment [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	Facility		2006	$ 627,000	1
2					2
3	TOTALS			$ 627,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Highland Park Nursing & Rehab # 0048330 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 Highland Park Nursing & Rehab # 0048330 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)		3,407,107	87,358		97,346	9,988	394,928	67
68	Related Party Allocations (Pages 12H & 12I)		78,545	855		1,248	393	1,368	68
69	Financial Statement Depreciation			25,614			(25,614)		69
70	TOTAL (lines 4 thru 69)		$ 3,485,652	$ 113,827		$ 98,594	$ (15,233)	$ 396,296	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Highland Park Nursing & Rehab # 0048330 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		$ 3,485,652	$ 113,827		$ 98,594	$ (15,233)	$ 396,296	1
2	Water Heater	2007	3,160		20	158	158	619	2
3	New Roof	2007	26,250		20	2,625	2,625	9,844	3
4	Econocare - Window Treatments	2007	2,605		20	261	261	977	4
5	Heat Exchanger & Belt	2007	2,900		20	145	145	544	5
6	Evanston Awning	2007	2,027		20	203	203	709	6
7	Ls Electric Services - Wall Receptacles	2007	1,379		20	138	138	483	7
8	Corridor, Dayroom Improvements - Flooring	2007	26,384		20	2,638	2,638	9,015	8
9	Gabco Enterprises - Light Fixtures	2007	3,662		20	366	366	1,221	9
10	New Drop Ceiling - Schwartz Bros	2007	6,580		20	658	658	2,193	10
11	Pipe Instillation For Sprinklers	2007	8,998		20	900	900	2,999	11
12	Acan Windows	2007	13,622		20	1,362	1,362	4,427	12
13	Maytav Construction - Corridor/Activity Room Ceiling Tile	2007	2,970		20	297	297	965	13
14	Alextronics Systems - Electronic Repairs	2007	4,400		20	629	629	1,938	14
15	Windows	2008	2,023		20	202	202	590	15
16	Cabinets	2008	2,445		20	245	245	693	16
17	Cublicle Tracks, Cornice Boxes, Curtains & Bedspreads	2008	19,859		20	3,972	3,972	10,591	17
18	Installation Of Lights, Smoke Detector And Tv Jacks	2008	930		20	46	46	139	18
19	Cubicle Curtains And Tracks	2008	1,020		20	102	102	272	19
20	Security System - Usa Satellite	2009	5,198		20	1,040	1,040	1,386	20
21	Install New Water Heater	2009	7,950		20	795	795	861	21
22	Installed New Bracket Wheels Bearing And Shaft, Install/Rewire N	2009	2,590		20	259	259	281	22
23	Annunciator - East Entrance	2010	2,505		20	230	230	230	23
24	Innovative Process - Two Lite Slider	2010	8,368		20	628	628	628	24
25	Usa Cable And Satelite	2010	12,500		20	729	729	729	25
26	Usa Satellite - Fire Alarm, Nurse Call, Phone, Door Systems	2010	35,000		20	1,750	1,750	1,750	26
27	Dgtell - Nortel Key Service, Analog Station Module, Inv#1763	2010	9,124		20	380	380	380	27
28	Keypad Entry	2010	3,342		20	139	139	139	28
29	Architectural (Sas#1560)	2010	3,286		20	82	82	82	29
30	Architectural Svcs (Sas#1510)	2010	4,050		20	135	135	135	30
31	3 Rooms To Nurse Call System	2010	3,025		20	76	76	76	31
32	Install 162 Nurse Call Stations	2010	8,395		20	420	420	420	32
33	Duro-Last Roofing System	2010	13,478		20	225	225	225	33
34	TOTAL (lines 1 thru 33)		$ 3,735,676	$ 113,827		$ 120,427	$ 6,600	$ 451,836	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Highland Park Nursing & Rehab # 0048330 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		$ 3,735,676	$ 113,827		$ 120,427	$ 6,600	$ 451,836	1
2	4 Bathrooms - Wall, Floor Tiles, Fixtures, Plumbing, Electrical	2010	18,000		20	150	150	150	2
3	Fire Alarm System (Convergint Contract)	2010	10,000		20	250	250	250	3
4	Laundry Exhaust Pipe	2010	4,600		20	77	77	77	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,768,276	$ 113,827		$ 120,903	$ 7,076	$ 452,313	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Highland Park Nursing & Rehab # 0048330 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		$ 3,768,276	$ 113,827		$ 120,903	$ 7,076	$ 452,313	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,768,276	$ 113,827		$ 120,903	$ 7,076	$ 452,313	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Highland Park Nursing & Rehab # 0048330 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		$ 3,768,276	$ 113,827		$ 120,903	$ 7,076	$ 452,313	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,768,276	$ 113,827		$ 120,903	$ 7,076	$ 452,313	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Highland Park Nursing & Rehab # 0048330 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	Highland Park NRC Realty	1961	3,407,107	87,358	35	97,346	9,988	394,928	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 Highland Park Nursing & Rehab # 0048330 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
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$ 3,407,107	$ 87,358		$ 97,346	$ 9,988	$ 394,928	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Highland Park Nursing & Rehab # 0048330 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 8131 N. Monticello	2010	55,407	587		586	(1)	586	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated 8131 N. Monticello		19,262	246	20	518	272	518	9
10	Allocated YAM Management	2007	1,331	4	20	67	63	208	10
11	Allocated YAM Management	2008	92	1	20	4	3		11
12	Allocated YAM Management	2009	404	5	20	17	12		12
13	Allocated YAM Management	2010	2,049	12	20	56	44	56	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 Highland Park Nursing & Rehab # 0048330 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
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 78,545	$ 855		$ 1,248	$ 393	$ 1,368	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Highland Park Nursing & Rehab # 0048330 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	$ 297,002	$ 45,518	$ 39,879	$ (5,640)	10	$ 239,392	71
72	Current Year Purchases	42,883	5,631	2,567	(3,064)	10	2,567	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 339,885	$ 51,149	$ 42,445	$ (8,704)		$ 241,959	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		2009 GMC Savana	2009	$ 46,762	$ 8,179	$ 8,242	$ 63	5	$ 15,256	76
77		Allocated YAM Management	2009	1,469	168	262	94	5	857	77
78										78
79										79
80	TOTALS			$ 48,231	$ 8,347	$ 8,504	$ 157		$ 16,113	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)	$ 4,783,392	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 173,323	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 171,853	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,470)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 710,385	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 Highland Park Nursing & Rehab # 0048330 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? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from YAM Management				1,661			5
6								6
7	TOTAL				$ 1,661 **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 5,990 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	Auto Lease		$	$ 1,750	17
18	Allocated from YAM Management			643	18
19	Allocated from YAM Consulting			3,463	19
20					20
21	TOTAL		$	$ 5,856	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 Highland Park Nursing & Rehab # 0048330 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 Highland Park Nursing & Rehab # 0048330 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	$		$ 170,052	$		$ 170,052	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			81,320			81,320	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			173,364			173,364	4
5	Physician Care	39 - 03	visits			577			577	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				90,006		90,006	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						7,624		7,624	13
14	TOTAL			$		$ 425,313	$ 97,630		$ 522,943	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 Highland Park Nursing & Rehab # 0048330 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	$ 3,994	$ 405,106	1
2	Cash-Patient Deposits	23,566	23,566	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	611,074	611,074	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	47,851	47,851	6
7	Other Prepaid Expenses	273	273	7
8	Accounts Receivable (owners or related parties)	362,827	362,827	8
9	Other(specify): See Attached Schedule	78,560	9,460,446	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,128,145	$ 10,911,143	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		627,000	13
14	Buildings, at Historical Cost		3,407,107	14
15	Leasehold Improvements, at Historical Cost	281,153	281,153	15
16	Equipment, at Historical Cost	220,215	410,215	16
17	Accumulated Depreciation (book methods)	(145,130)	(699,138)	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	22,600	58,269	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 378,838	$ 4,084,606	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,506,983	$ 14,995,749	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 570,943	$ 549,789	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,045	24,045	28
29	Short-Term Notes Payable	551,061	551,061	29
30	Accrued Salaries Payable	77,221	77,221	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,283	4,283	31
32	Accrued Real Estate Taxes(Sch.IX-B)	48,000	48,000	32
33	Accrued Interest Payable	1,056	356	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	145,965	3,651,733	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,422,574	$ 4,906,488	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	14,722	6,475,954	39
40	Mortgage Payable		2,837,266	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule		100,000	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 14,722	$ 9,413,220	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,437,296	$ 14,319,708	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 69,687	$ 676,041	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,506,983	$ 14,995,749	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Highland Park Nursing & Rehab # 0048330 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**	$ 89,345	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 89,345	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	78,049	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	(97,707)	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)**	$ (19,658)	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)**	$ 69,687	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Highland Park Nursing & Rehab # 0048330 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	$ 3,390,262	1
2	Discounts and Allowances for all Levels	(226,225)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,164,037	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,157,595	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,157,595	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	91,166	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,335	19
20	Radiology and X-Ray	2,300	20
21	Other Medical Services	4,557	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 114,358	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	112	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 112	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	17,636	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 17,636	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,453,738	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	727,866	31
32	Health Care	1,522,505	32
33	General Administration	873,774	33
	B. Capital Expense		
34	Ownership	541,388	34
	C. Ancillary Expense		
35	Special Cost Centers	656,104	35
36	Provider Participation Fee	54,052	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,375,689	40
41	**Income before Income Taxes (line 30 minus line 40)****	78,049	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 78,049	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 Highland Park Nursing & Rehab # 0048330 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	2,007	2,078	$ 73,586	$ 35.41	1
2	Assistant Director of Nursing	652	663	20,742	31.29	2
3	Registered Nurses	14,406	15,994	446,547	27.92	3
4	Licensed Practical Nurses	5,452	6,299	165,295	26.24	4
5	CNAs & Orderlies	42,190	45,847	552,231	12.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,983	2,087	30,787	14.75	8
9	Activity Director					9
10	Activity Assistants	3,806	4,169	42,428	10.18	10
11	Social Service Workers	34	36	554	15.39	11
12	Dietician					12
13	Food Service Supervisor	2,167	2,358	37,610	15.95	13
14	Head Cook	3,546	4,105	42,228	10.29	14
15	Cook Helpers/Assistants	7,250	7,792	75,215	9.65	15
16	Dishwashers					16
17	Maintenance Workers	2,055	2,267	42,151	18.59	17
18	Housekeepers	8,292	9,008	98,977	10.99	18
19	Laundry	5,870	6,439	65,110	10.11	19
20	Administrator	1,903	2,202	79,907	36.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,885	6,283	98,947	15.75	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	465	500	6,449	12.90	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	107,963	118,127	$ 1,878,764 *	$ 15.90	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	463	$ 24,269	01-03	35
36	Medical Director	Monthly	32,500	09-03	36
37	Medical Records Consultant	7	356	10-03	37
38	Nurse Consultant	416	20,775	10-03	38
39	Pharmacist Consultant	Monthly	4,560	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	49	2,400	11-03	44
45	Social Service Consultant	82	2,726	12-03	45
46	Other(specify)				46
47	Psycho Social Consultant	Monthly	30,703	12-03	47
48					48
49	TOTAL (lines 35 - 48)	1,017	$ 118,289		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 Highland Park Nursing & Rehab # 0048330 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sarah Jakoubek	Administrator	0	$ 66,457
Etan Bleichamn	Administrator	0	13,450
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 79,907

B. Administrative - Other

Description	Amount
YAM Administrative Consulting	$ 1,200
Management Fees - Yosef Meystel	14,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 15,200
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal Fees	$ 11,140
YAM Management	Bookkeeping	101,871
E-Health Data Solutions	MDS Software	4,703
Personnel Planners	Unemployment Consultant	1,313
Prospect Resources	Energy Consultant	668
Frost, Ruttenberg & Rothblatt	Accounting Fees	27,200
Emdeon Business Services	Data Processing	5,518
Health Data Systems	Data Processing	3,064
HD Supply Facilities	Data Processing	288
YAM Management	Data Processing	22
American Data	Data Processing	302
See Supplemetal Schedule		7,726
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 163,814

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,025
Unemployment Compensation Insurance	15,886
FICA Taxes	141,548
Employee Health Insurance	76,430
Employee Meals	20,294
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	102
Union Pension Expense	16,129
TOTAL (agree to Schedule V, line 22, col.8)	$ 311,414

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	400
Health Care Worker Background Check	1,320
(Indicate # of checks performed 132)	
Patient Background Checks	
Licenses & Permits	2,199
Dues & Subscriptions	6,480
Fundraising & Promotions	31,417
Allocated from YAM Management	256
See Supplemental Schedule	134
Less: Public Relations Expense	( )
Non-allowable advertising	(31,417)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,789

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,359
Allocated from YAM Management	309
Allocated from YAM Consulting	610
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,278

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Highland Park Nursing & Rehab # 0048330 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 Highland Park Nursing & Rehab **#** 0048330 **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. **ICLTC: $6,797 IAHCF: $1,140**

(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. $ **18,072** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **54,052**
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. $ **20,294** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

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

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

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

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