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: 0050187

Facility Name: International Nursing & Rehab Center

Address: 4815 South Western Avenue (Number) Chicago (City) 60609 (Zip Code)

County: Cook

Telephone Number: (773) 927- 4200 **Fax #** (773) 927-1287

HFS ID Number:

Date of Initial License for Current Owners: 10/01/2008

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 International Nursing & Rehab Center # 0050187 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	218	Skilled (SNF)	218	79,570	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	218	TOTALS	218	79,570	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	47,081	1,840	6,642	55,563	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,081	1,840	6,642	55,563	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.83%

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 10/1/2008

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/1/2008 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 218 and days of care provided 6,642

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 International Nursing & Rehab Center # 0050187 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	292,482	28,496	26,359	347,337		347,337	(8,123)	339,214			1
2	Food Purchase		252,621		252,621	(22,667)	229,955	(84)	229,871			2
3	Housekeeping	192,361	31,906		224,267		224,267		224,267			3
4	Laundry	98,992	19,189		118,181		118,181		118,181			4
5	Heat and Other Utilities			284,914	284,914		284,914	2,302	287,216			5
6	Maintenance	60,782		111,942	172,724		172,724	7,785	180,509			6
7	Other (specify):*							3,004	3,004			7
8	**TOTAL General Services**	644,617	332,212	423,215	1,400,044	(22,667)	1,377,378	4,884	1,382,261			8
	B. Health Care and Programs											
9	Medical Director			33,566	33,566		33,566		33,566			9
10	Nursing and Medical Records	2,661,223	156,161	120,839	2,938,223		2,938,223	(42,436)	2,895,787			10
10a	Therapy	102,384		350	102,734		102,734		102,734			10a
11	Activities	141,906	6,294	4,822	153,022		153,022		153,022			11
12	Social Services	63,632		2,387	66,019		66,019	397	66,416			12
13	CNA Training											13
14	Program Transportation			5,086	5,086		5,086	4,422	9,508			14
15	Other (specify):*							8,599	8,599			15
16	**TOTAL Health Care and Programs**	2,969,145	162,455	167,050	3,298,650		3,298,650	(29,018)	3,269,632			16
	C. General Administration											
17	Administrative	143,503		64,000	207,503		207,503	29,944	237,447			17
18	Directors Fees											18
19	Professional Services			323,356	323,356	(31,670)	291,686	(162,119)	129,567			19
20	Dues, Fees, Subscriptions & Promotions			62,729	62,729		62,729	(3,797)	58,932			20
21	Clerical & General Office Expenses	141,843	647	328,150	470,640		470,640	(105,274)	365,366			21
22	Employee Benefits & Payroll Taxes			723,119	723,119	22,667	745,786		745,786			22
23	Inservice Training & Education											23
24	Travel and Seminar							2,031	2,031			24
25	Other Admin. Staff Transportation			681	681		681	3,274	3,955			25
26	Insurance-Prop.Liab.Malpractice			311,407	311,407		311,407	2,700	314,107			26
27	Other (specify):*							30,134	30,134			27
28	**TOTAL General Administration**	285,346	647	1,813,442	2,099,435	(9,004)	2,090,432	(203,107)	1,887,324			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,899,108	495,314	2,403,707	6,798,129	(31,670)	6,766,459	(227,241)	6,539,218			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 International Nursing & Rehab Center #0050187 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			27,001	27,001		27,001	29	27,030			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			94,297	94,297		94,297	8,916	103,213			32
33	Real Estate Taxes			304,184	304,184	31,670	335,854	4,308	340,162			33
34	Rent-Facility & Grounds			1,425,925	1,425,925		1,425,925	(11,832)	1,414,093			34
35	Rent-Equipment & Vehicles			16,471	16,471		16,471	10,115	26,586			35
36	Other (specify):*			1	1		1		1			36
37	**TOTAL Ownership**			1,867,879	1,867,879	31,670	1,899,549	11,537	1,911,086			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		396,259	1,037,289	1,433,548		1,433,548		1,433,548			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			119,355	119,355		119,355		119,355			42
43	Other (specify):*	26,085		353,915	380,000		380,000	(380,000)	0			43
44	**TOTAL Special Cost Centers**	26,085	396,259	1,510,559	1,932,903		1,932,903	(380,000)	1,552,903			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,925,193	891,573	5,782,145	10,598,911		10,598,911	(595,704)	10,003,207			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 International Nursing & Rehab Center # 0050187 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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(10,097)	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	(8,496)	30		9
10	Interest and Other Investment Income	(27)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(84)	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	(11,040)	21		18
19	Entertainment	(6,911)	21		19
20	Contributions	(4,150)	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	(206,819)	21		24
25	Fund Raising, Advertising and Promotional	(234)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(351,694)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (599,552)		$	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)	3,848		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 3,848		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (595,704)		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

STATE OF ILLINOIS

International Nursing & Rehab Center

ID# 0050187

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (13,416)	21	1
2	Marketing Salary	(26,085)	43	2
3	Other Marketing Expense	(1,455)	43	3
4	Bank Charges	(8,347)	21	4
5	Secretary of State - Annual Report	(275)	20	5
6	Additional R&M	12,109	06	6
7	Non-Allowable Legal	(1,425)	19	7
8	Non-Allowable Expense	(311,000)	43	8
9	Non-Allowable Loan Costs	(1,800)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(351,694)		49

International Nursing & Rehab Center

ID# 0050187

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 International Nursing & Rehab Center **#** 0050187 **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				(8,123)								(8,123)	1
2	Food Purchase	(84)											(84)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			2,302									2,302	5
6	Maintenance	2,012		5,672		101							7,785	6
7	Other (specify):*			889	2,115								3,004	7
8	**TOTAL General Services**	1,928		8,863	(6,008)	101							4,884	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				(42,436)								(42,436)	10
10a	Therapy													10a
11	Activities													11
12	Social Services				397								397	12
13	CNA Training													13
14	Program Transportation				4,422								4,422	14
15	Other (specify):*				8,599								8,599	15
16	**TOTAL Health Care and Programs**				(29,018)								(29,018)	16
	C. General Administration													
17	Administrative			15,956	13,988								29,944	17
18	Directors Fees													18
19	Professional Services	(1,425)		(145,101)	(19,270)	3,677							(162,119)	19
20	Fees, Subscriptions & Promotions	(4,659)		565	104	193							(3,797)	20
21	Clerical & General Office Expenses	(248,334)		128,039	14,934	87							(105,274)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			683	1,348								2,031	24
25	Other Admin. Staff Transportation			2,866	407								3,274	25
26	Insurance-Prop.Liab.Malpractice			2,700									2,700	26
27	Other (specify):*			26,149	3,985								30,134	27
28	**TOTAL General Administration**	(254,418)		31,857	15,496	3,957							(203,107)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(252,489)		40,720	(19,529)	4,057							(227,241)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number International Nursing & Rehab Center **#** 0050187 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(8,496)		6,612	74	1,838							29	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(27)		46		8,897							8,916	32
33	Real Estate Taxes			4,093		215							4,308	33
34	Rent-Facility & Grounds			8,369		(20,201)							(11,832)	34
35	Rent-Equipment & Vehicles			2,469	7,647								10,115	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(8,523)		21,589	7,721	(9,250)							11,537	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):*	(338,540)			(41,460)								(380,000)	43
44	**TOTAL Special Cost Centers**	(338,540)			(41,460)								(380,000)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(599,552)		62,309	(53,269)	(5,193)							(595,704)	45

Facility Name & ID Number International Nursing & Rehab Center # 0050187 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		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. [ ] YES [X] 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			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number International Nursing & Rehab Center # 0050187 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%	$ 2,302	$ 2,302	15
16	V	6	REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	5,672	5,672	16
17	V	7	EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	889	889	17
18	V	17	ADMIN. - RELATED		YAM MANAGEMENT, LLC	100.00%	11,309	11,309	18
19	V	17	ADMIN. - NON RELATED		YAM MANAGEMENT, LLC	100.00%	4,647	4,647	19
20	V	19	PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	10,251	10,251	20
21	V	20	FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	565	565	21
22	V	21	CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	128,039	128,039	22
23	V	24	SEMINARS		YAM MANAGEMENT, LLC	100.00%	683	683	23
24	V	25	AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	2,866	2,866	24
25	V	26	INSURANCE		YAM MANAGEMENT, LLC	100.00%	2,700	2,700	25
26	V	27	EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	26,149	26,149	26
27	V	30	DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	6,612	6,612	27
28	V	32	INTEREST		YAM MANAGEMENT, LLC	100.00%	46	46	28
29	V	33	REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%	4,093	4,093	29
30	V	34	RENT		YAM MANAGEMENT, LLC	100.00%	23,869	23,869	30
31	V	35	AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	1,421	1,421	31
32	V	35	EQUIPMENT RENTAL		YAM MANAGEMENT, LLC	100.00%	1,048	1,048	32
33	V								33
34	V								34
35	V	19	BOOKKEEPING FEES	119,352	YAM MANAGEMENT, LLC	100.00%		(119,352)	35
36	V	19	ACCOUNTING	36,000	YAM MANAGEMENT, LLC	100.00%		(36,000)	36
37	V	34	RENT	15,500	YAM MANAGEMENT, LLC	100.00%		(15,500)	37
38	V								38
39	Total			$ 170,852			$ 233,161	$ * 62,309	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Nursing & Rehab Center # 0050187 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	1	DIETARY	$	YAM CONSULTING, LLC	100.00%	$ 18,236	$ 18,236	15
16	V	7	EMP. BEN. GEN. SERV.		YAM CONSULTING, LLC	100.00%	2,115	2,115	16
17	V	10	NURSING SALARY		YAM CONSULTING, LLC	100.00%	68,558	68,558	17
18	V	12	SOCIAL SERVICES SALARY		YAM CONSULTING, LLC	100.00%	397	397	18
19	V	14	PROGRAM TRANSPORTATION		YAM CONSULTING, LLC	100.00%	4,422	4,422	19
20	V	15	EMP. BEN. HEALTHCARE		YAM CONSULTING, LLC	100.00%	8,599	8,599	20
21	V	17	ADMIN. - NON RELEATED		YAM CONSULTING, LLC	100.00%	13,988	13,988	21
22	V	19	PROFESSIONAL FEES		YAM CONSULTING, LLC	100.00%	350	350	22
23	V	20	FEES, SUBSCRIPTIONS		YAM CONSULTING, LLC	100.00%	104	104	23
24	V	21	CLERICAL & GENERAL		YAM CONSULTING, LLC	100.00%	14,934	14,934	24
25	V	24	SEMINARS		YAM CONSULTING, LLC	100.00%	1,348	1,348	25
26	V	25	AUTO AND TRAVEL		YAM CONSULTING, LLC	100.00%	407	407	26
27	V	27	EMP. BEN.-GEN. ADMIN.		YAM CONSULTING, LLC	100.00%	3,985	3,985	27
28	V	30	DEPRECIATION		YAM CONSULTING, LLC	100.00%	74	74	28
29	V	35	AUTO RENTAL		YAM CONSULTING, LLC	100.00%	7,647	7,647	29
30	V								30
31	V								31
32	V								32
33	V	10	NURSING CONSULTING	110,994				(110,994)	33
34	V	01	DIETARY CONSULTING	26,359				(26,359)	34
35	V								35
36	V	19	DATA PROCESSING FEES	19,620				(19,620)	36
37	V	43	MARKETING	41,460				(41,460)	37
38	V								38
39	Total			$ 198,433			$ 145,164	$ * (53,269)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Nursing & Rehab Center # 0050187 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%	$ 101	$ 101	15
16	V	19	PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		3,677	3,677	16
17	V	20	DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		193	193	17
18	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		87	87	18
19	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		1,838	1,838	19
20	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		8,897	8,897	20
21	V	33	REAL ESTATE TAXES	4,093	8131 N. MONTICELLO, LLC		4,308	215	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	20,201	8131 N. MONTICELLO, LLC			(20,201)	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			$ 24,294			$ 19,101	$ * (5,193)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Nursing & Rehab Center # 0050187 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 International Nursing & Rehab Center # 0050187 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 International Nursing & Rehab Center # 0050187 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 International Nursing & Rehab Center # 0050187 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 International Nursing & Rehab Center # 0050187 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 International Nursing & Rehab Center # 0050187 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 International Nursing & Rehab Center # 0050187 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	27.5%	See Attached	5.5	14%	Mgmt. Fees	$ 24,000	17-03	1
2	David Berkowitz	Owner	Administrative	27.5%	See Attached	5.5	14%	Mgmt. Fees	40,000	17-03	2
3	Jay Meystel	Relative	Administrative	0.00%	See Attached	2.7	7%	Alloc. Salary	7,822	17-07	3
4	Joel Meystel	Relative	Administrative	0.00%	See Attached	2.7	14%	Alloc. Salary	3,487	17-07	4
5	Joshua Weinstein	Owner	Administrative	3.00%	See Attached	5.5	14%	Alloc. Salary	18,635	17-07	5
6	Shimon Meystel	Relative	Clerical	0.00%	See Attached	5.5	14%	Alloc. Salary	1,853	21-07	6
7	Meir Meystel	Relative	Administrative	0.00%	None	32.8	82%	Alloc. Salary	30,469	17-01	7
8											8
9											9
10	Where applicable, the amounts reported on this page have been adjusted from the actual costs to										10
11	reflect only amounts anticipated to be considered allowable by the Illinois Department of HFS.										11
12											12
13								TOTAL	$ 126,266		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 International Nursing & Rehab Center # 0050187 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 International Nursing & Rehab Center # 0050187 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	$	79,570	$ 2,302	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	579,474	16	41,306	29,925	79,570	5,672	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	579,474	16	6,478		79,570	889	3
4	17	ADMIN. - RELATED	AVAIL. BED DAYS	579,474	16	82,362	82,362	79,570	11,309	4
5	17	ADMIN. - NON RELATED	AVAIL. BED DAYS	579,474	16	33,843	33,843	79,570	4,647	5
6	19	PROFESSIONAL FEES	AVAIL. BED DAYS	579,474	16	74,656		79,570	10,251	6
7	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	579,474	16	4,114		79,570	565	7
8	21	CLERICAL & GENERAL	AVAIL. BED DAYS	579,474	16	932,452	841,703	79,570	128,039	8
9	24	SEMINARS	AVAIL. BED DAYS	579,474	16	4,974		79,570	683	9
10	25	AUTO AND TRAVEL	AVAIL. BED DAYS	579,474	16	20,872		79,570	2,866	10
11	26	INSURANCE	AVAIL. BED DAYS	579,474	16	19,661		79,570	2,700	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	579,474	16	190,434		79,570	26,149	12
13	30	DEPRECIATION	AVAIL. BED DAYS	579,474	16	48,156		79,570	6,612	13
14	32	INTEREST	AVAIL. BED DAYS	579,474	16	331		79,570	46	14
15	33	REAL ESTATE TAX	AVAIL. BED DAYS	579,474	16	29,806		79,570	4,093	15
16	34	RENT	AVAIL. BED DAYS	579,474	16	173,825		79,570	23,869	16
17	35	AUTO RENTAL	AVAIL. BED DAYS	579,474	16	10,347		79,570	1,421	17
18	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	579,474	16	7,632		79,570	1,048	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,698,015	$ 987,832		$ 233,161	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Nursing & Rehab Center # 0050187 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	79,570	$ 18,236	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	579,474	16	15,402		79,570	2,115	2
3	10	NURSING SALARY	AVAIL. BED DAYS	579,474	16	499,281	499,281	79,570	68,558	3
4	12	SOCIAL SERVICES SALARY	AVAIL. BED DAYS	579,474	16	2,888	2,888	79,570	397	4
5	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	579,474	16	32,206		79,570	4,422	5
6	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	579,474	16	62,625		79,570	8,599	6
7	17	ADMIN. - NON RELEATED	AVAIL. BED DAYS	579,474	16	101,866	101,866	79,570	13,988	7
8	19	PROFESSIONAL FEES	AVAIL. BED DAYS	579,474	16	2,550		79,570	350	8
9	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	579,474	16	755		79,570	104	9
10	21	CLERICAL & GENERAL	AVAIL. BED DAYS	579,474	16	108,757	86,009	79,570	14,934	10
11	24	SEMINARS	AVAIL. BED DAYS	579,474	16	9,816		79,570	1,348	11
12	25	AUTO AND TRAVEL	AVAIL. BED DAYS	579,474	16	2,967		79,570	407	12
13	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	579,474	16	29,022		79,570	3,985	13
14	30	DEPRECIATION	AVAIL. BED DAYS	579,474	16	539		79,570	74	14
15	35	AUTO RENTAL	AVAIL. BED DAYS	579,474	16	55,686		79,570	7,647	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		$ 145,164	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Nursing & Rehab Center # 0050187 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	$	79,570	$ 101	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	579,474	16	26,780		79,570	3,677	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	579,474	16	1,405		79,570	193	3
4	21	OFFICE EXPENSE	PATIENT DAYS	579,474	16	630		79,570	87	4
5	30	DEPRECIATION	PATIENT DAYS	579,474	16	13,389		79,570	1,838	5
6	32	INTEREST EXPENSE	PATIENT DAYS	579,474	16	64,796		79,570	8,897	6
7	33	REAL ESTATE TAXES	PATIENT DAYS	579,474	16	31,375		79,570	4,308	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	$		$ 19,101	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Nursing & Rehab Center # 0050187 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 International Nursing & Rehab Center # 0050187 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 International Nursing & Rehab Center # 0050187 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 International Nursing & Rehab Center # 0050187 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 International Nursing & Rehab Center # 0050187 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
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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 International Nursing & Rehab Center # 0050187 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 International Nursing & Rehab Center # 0050187 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							$	$			$	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	First Bank		X	Line of Credit				897,648			86,452	6
7	Assurance		X	Insurance Financing							3,660	7
8	See Supplemental Schedule										4,185	8
9	TOTAL Facility Related						$	$ 897,648			$ 94,297	9
	B. Non-Facility Related*											
10	Interest Income		X								(27)	10
11	YAM Management Allocation	X									46	11
12	8131 N. Monticello Allocation	X									8,897	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ 8,916	14
15	TOTALS (line 9+line14)						$	$ 897,648			$ 103,213	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 International Nursing & Rehab Center # 0050187 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	Assurance		X	Insurance Financing			$	$			$ 4,185	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										4,185	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 International Nursing & Rehab Center # 0050187 **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.	$	281,000	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.)	$	294,492	2
3. Under or (over) accrual (line 2 minus line 1).	$	13,492	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	295,000	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.**	$	31,670	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.	$	340,162	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005		8
2006		9
2007		10
2008	280,157	11
2009	290,184	12

2010 Accrual = 2009 Tax (Rounded)
8131 N. Monticello Allocation = $4,308

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 International Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050187

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.	20-07-104-001-0000	Long Term Care Property	$ 179,273.58	$ 179,273.58
2.	20-07-104-003-0000	Long Term Care Property	$ 2,424.64	$ 2,424.64
3.	20-07-104-004-0000	Long Term Care Property	$ 1,269.60	$ 1,269.60
4.	20-07-104-005-0000	Long Term Care Property	$ 677.07	$ 677.07
5.	20-07-104-009-0000	Long Term Care Property	$ 54,459.65	$ 54,459.65
6.	20-07-104-011-0000	Long Term Care Property	$ 51,092.58	$ 51,092.58
7.	20-07-104-012-0000	Long Term Care Property	$ 987.22	$ 987.22
8.	Allocated from 8131 N. Monticello	Home Office Allocation	$ 30,331.21	$ 4,164.91
9.			$	$
10.			$	$
		TOTALS	$ 320,515.55	$ 294,349.25

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 International Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050187

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 International Nursing & Rehab Center # 0050187 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 89,132 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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				$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Nursing & Rehab Center # 0050187 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 International Nursing & Rehab Center # 0050187 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)								67
68	Related Party Allocations (Pages 12H & 12I)		173,441	1,886		2,754	868	3,021	68
69	Financial Statement Depreciation			3,884			(3,884)		69
70	TOTAL (lines 4 thru 69)		$ 173,441	$ 5,770		$ 2,754	$ (3,016)	$ 3,021	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number International Nursing & Rehab Center # 0050187 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		$ 173,441	$ 5,770		$ 2,754	$ (3,016)	$ 3,021	1
2	Plumbing Work	2009	23,882		20	2,388	2,388	3,980	2
3	Refrigeration System	2010	14,156		20	1,416	1,416	1,416	3
4	Vinyl Tile	2010	4,353		20	109	109	109	4
5	New Floor Installation	2010	13,988		20	116	116	116	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)		$ 229,820	$ 5,770		$ 6,783	$ 1,013	$ 8,642	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number International Nursing & Rehab Center # 0050187 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		$ 229,820	$ 5,770		$ 6,783	$ 1,013	$ 8,642	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$ 229,820	$ 5,770		$ 6,783	$ 1,013	$ 8,642	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number International Nursing & Rehab Center # 0050187 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		$ 229,820	$ 5,770		$ 6,783	$ 1,013	$ 8,642	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 229,820	$ 5,770		$ 6,783	$ 1,013	$ 8,642	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number International Nursing & Rehab Center # 0050187 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		$ 229,820	$ 5,770		$ 6,783	$ 1,013	$ 8,642	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 229,820	$ 5,770		$ 6,783	$ 1,013	$ 8,642	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number International Nursing & Rehab Center # 0050187 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									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
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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 International Nursing & Rehab Center # 0050187 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$	$		$	$	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number International Nursing & Rehab Center # 0050187 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 8131 N. Monticello	2010	122,350	1,296	39	1,294	(2)	1,294	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from 8131 N. Monticello	2010	42,535	542	20	1,145	603	1,145	9
10	Allocated from YAM Management	2007	2,938	9	20	147	138	459	10
11	Allocated from YAM Management	2008	202	2	20	8	6		11
12	Allocated from YAM Management	2009	892	10	20	37	27		12
13	Allocated from YAM Management	2010	4,524	27	20	123	96	123	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
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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 International Nursing & Rehab Center # 0050187 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 173,441	$ 1,886		$ 2,754	$ 868	$ 3,021	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number International Nursing & Rehab Center # 0050187 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	$ 68,652	$ 21,253	$ 18,549	$ (2,704)	10	$ 39,546	71
72	Current Year Purchases	11,179	8,129	1,118	(7,011)	10	1,118	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 79,831	$ 29,382	$ 19,667	$ (9,715)		$ 40,664	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated YAM Management	2009	$ 3,245	$ 372	$ 579	$ 207	5	$ 1,893	76
77										77
78										78
79										79
80	TOTALS			$ 3,245	$ 372	$ 579	$ 207		$ 1,893	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)	$ 312,896	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 35,524	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 27,028	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (8,496)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 51,199	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 International Nursing & Rehab Center # 0050187 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: Albany Bank and Trust Company, N.A.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		218		$ 1,410,425			3
4	Additions							4
5	Allocated from YAM Management				3,668			5
6								6
7	TOTAL		218		$ 1,414,093 **			7

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

9. Option to Buy: [X] YES [ ] NO Terms: Option to buy in 2012 *

10. Effective dates of current rental agreement:
    Beginning November 1, 2008
    Ending October 31, 2027

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

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

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 12,339 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 Leasing		$	$ 5,180	17
18	Allocated from YAM Management			1,421	18
19	Allocated from YAM Consulting			7,647	19
20					20
21	TOTAL		$	$ 14,248	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 International Nursing & Rehab Center # 0050187 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 International Nursing & Rehab Center # 0050187 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 Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 416,014	$		$ 416,014	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			175,894			175,894	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			444,113			444,113	4
5	Physician Care	39 - 03	visits			1,268			1,268	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				341,749		341,749	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						54,510		54,510	13
14	TOTAL			$		$ 1,037,289	$ 396,259		$ 1,433,548	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 International Nursing & Rehab Center # 0050187 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	$ 2,276	$	1
2	Cash-Patient Deposits	53,396		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,236,174		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	235,004		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,156,801		8
9	Other(specify): See Attached Schedule	703,540		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,387,191	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	51,437		15
16	Equipment, at Historical Cost	101,975		16
17	Accumulated Depreciation (book methods)	(49,684)		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	8,200		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 111,928	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,499,119	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,220,108	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	53,395		28
29	Short-Term Notes Payable	897,648		29
30	Accrued Salaries Payable	204,422		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,265		31
32	Accrued Real Estate Taxes(Sch.IX-B)	295,000		32
33	Accrued Interest Payable	5,039		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	60,994		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,751,871	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,751,871	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 747,248	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,499,119	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number International Nursing & Rehab Center # 0050187 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**	$ 845,589	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 845,589	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	248,326	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	(346,667)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (98,341)	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)**	$ 747,248	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Nursing & Rehab Center # 0050187 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	$ 8,337,448	1
2	Discounts and Allowances for all Levels	(628,269)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,709,179	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,772,364	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,772,364	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	301,501	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30,682	19
20	Radiology and X-Ray	5,025	20
21	Other Medical Services	15,043	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 352,251	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	27	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 27	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	13,416	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,416	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,847,237	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,400,044	31
32	Health Care	3,298,650	32
33	General Administration	2,099,435	33
	B. Capital Expense		
34	Ownership	1,867,879	34
	C. Ancillary Expense		
35	Special Cost Centers	1,813,548	35
36	Provider Participation Fee	119,355	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,598,911	40
41	**Income before Income Taxes (line 30 minus line 40)****	248,326	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 248,326	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 International Nursing & Rehab Center # 0050187 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	1,709	1,853	$ 71,154	$ 38.40	1
2	Assistant Director of Nursing	1,514	1,793	63,289	35.30	2
3	Registered Nurses	10,979	11,683	356,566	30.52	3
4	Licensed Practical Nurses	47,466	49,883	1,273,319	25.53	4
5	CNAs & Orderlies	79,191	85,558	872,693	10.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,495	10,259	102,384	9.98	8
9	Activity Director	930	1,004	17,660	17.59	9
10	Activity Assistants	11,966	13,274	124,246	9.36	10
11	Social Service Workers	3,629	3,855	63,632	16.51	11
12	Dietician					12
13	Food Service Supervisor	1,989	2,110	53,141	25.19	13
14	Head Cook	5,861	6,277	71,144	11.33	14
15	Cook Helpers/Assistants	15,248	16,397	168,197	10.26	15
16	Dishwashers					16
17	Maintenance Workers	2,037	2,126	60,782	28.59	17
18	Housekeepers	19,060	20,834	192,361	9.23	18
19	Laundry	9,550	10,516	98,992	9.41	19
20	Administrator	2,037	2,190	113,034	51.61	20
21	Assistant Administrator	1,708	1,822	30,469	16.72	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,749	10,606	141,843	13.37	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	740	793	24,202	30.52	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,178	1,297	26,086	20.11	33
34	TOTAL (lines 1 - 33)	236,036	254,130	$ 3,925,194 *	$ 15.45	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	527	$ 26,359	01-03	35
36	Medical Director	Monthly	33,566	09-03	36
37	Medical Records Consultant		(620)	10-03	37
38	Nurse Consultant	Monthly	110,995	10-03	38
39	Pharmacist Consultant	Monthly	10,464	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	95	4,822	11-03	44
45	Social Service Consultant	43	2,387	12-03	45
46	Other(specify)				46
47					47
48	Restorative Therapy Consultant	Monthly	350	10-03	48
49	TOTAL (lines 35 - 48)	665	$ 188,323		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 International Nursing & Rehab Center # 0050187 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nikki Dinsmore	Administrator	0	$ 94,237
Chuck Slagel	Administrator	0	18,798
Meir Meystel	Asst. Administrator	0	30,469
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 143,503

B. Administrative - Other

Description	Amount
Management Fees - Yosef Meystel	$ 24,000
Management Fees - David Berkowitz	40,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 64,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 32,250
See Attached	Legal Fees	38,846
LTC Solutions, Inc.	Data Processing	2,368
Health Data Solutions, Inc.	Data Processing	6,990
E-Health Data Solutions	Data Processing	7,491
Personnel Planners	Unemployment Consulting	4,837
Allscripts	Computer Services	1,198
CES Consulting	Consulting	81
Michigan Peer Review Org.	Peer Review	1,681
Pathway Health Services	Consulting	34,180
IFMC	Quality Improvement	12,184
See Supplemetal Schedule		181,250
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 323,355

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 131,409
Unemployment Compensation Insurance	90,449
FICA Taxes	300,149
Employee Health Insurance	150,914
Employee Meals	22,667
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	34,689
Life Insurance	15,509
TOTAL (agree to Schedule V, line 22, col.8)	$ 745,785

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	27,060
Health Care Worker Background Check	2,455
(Indicate # of checks performed 245)	
Patient Background Checks	
Dues & Subscriptions	23,494
License & Permits	5,061
Allocated from YAM Management	565
Allocated from YAM Consulting	104
See Supplemental Schedule	193
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 58,932

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Allocated from YAM Management	683
Allocated from YAM Consulting	1,348
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,031

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Nursing & Rehab Center # 0050187 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 International Nursing & Rehab Center # 0050187 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: $19,260.30 IAHCF: $2,616**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **26,309** 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. $ **119,355**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **22,667** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

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

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

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

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