

Facility Name & ID Number Rockford Nursing & Rehab Ctr

0050435 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>52</u>	Skilled (SNF)	<u>52</u>	<u>18,980</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>45</u>	Intermediate (ICF)	<u>45</u>	<u>16,425</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>97</u>	TOTALS	<u>97</u>	<u>35,405</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	4 Other	5 Total		
8	SNF	<u>997</u>		<u>1,736</u>	<u>2,733</u>	8	
9	SNF/PED					9	
10	ICF	<u>13,249</u>	<u>517</u>	<u>8,320</u>	<u>22,086</u>	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>14,246</u>	<u>517</u>	<u>10,056</u>	<u>24,819</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.10%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 04/01/09

J. Was the facility purchased or leased after January 1, 1978?
YES Date 04/01/09 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 52 and days of care provided 1,736

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Rockford Nursing & Rehab Ctr # 0050435 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	164,153	18,608	13,448	196,209		196,209	(5,334)	190,876		1
2	Food Purchase		113,089		113,089	(12,319)	100,770	(24)	100,747		2
3	Housekeeping	59,450	14,749		74,199		74,199		74,199		3
4	Laundry	50,585	7,564	6,459	64,608		64,608		64,608		4
5	Heat and Other Utilities			112,223	112,223		112,223	1,024	113,247		5
6	Maintenance	69,171	15,324	56,744	141,239		141,239	10,036	151,275		6
7	Other (specify):*							1,337	1,337		7
8	TOTAL General Services	343,359	169,334	188,874	701,567	(12,319)	689,248	7,040	696,288		8
	B. Health Care and Programs										
9	Medical Director			13,690	13,690		13,690		13,690		9
10	Nursing and Medical Records	1,200,856	101,801	46,691	1,349,348		1,349,348	(12,422)	1,336,926		10
10a	Therapy	17,468	114		17,582		17,582		17,582		10a
11	Activities	54,358	2,407		56,765		56,765		56,765		11
12	Social Services	42,111		5,013	47,124		47,124	176	47,300		12
13	CNA Training										13
14	Program Transportation			3,593	3,593		3,593	1,968	5,561		14
15	Other (specify):*							3,826	3,826		15
16	TOTAL Health Care and Programs	1,314,793	104,322	68,987	1,488,102		1,488,102	(6,452)	1,481,650		16
	C. General Administration										
17	Administrative	82,872		91,400	174,272		174,272	(49,076)	125,196		17
18	Directors Fees										18
19	Professional Services			163,990	163,990		163,990	(120,840)	43,150		19
20	Dues, Fees, Subscriptions & Promotions			9,063	9,063		9,063	163	9,226		20
21	Clerical & General Office Expenses	57,600	924	122,476	181,000		181,000	(31,964)	149,036		21
22	Employee Benefits & Payroll Taxes			282,996	282,996	12,319	295,315		295,315		22
23	Inservice Training & Education										23
24	Travel and Seminar			25	25		25	904	929		24
25	Other Admin. Staff Transportation			1,770	1,770		1,770	1,457	3,227		25
26	Insurance-Prop.Liab.Malpractice			56,069	56,069		56,069	1,201	57,270		26
27	Other (specify):*							13,408	13,408		27
28	TOTAL General Administration	140,472	924	727,789	869,185	12,319	881,504	(184,747)	696,757		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,798,624	274,580	985,650	3,058,854		3,058,854	(184,159)	2,874,695		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

Rockford Nursing & Rehab Ctr

#0050435

Report Period Beginning:

01/01/10

Ending:

12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			115,774	115,774		115,774	(105,706)	10,068			30
31	Amortization of Pre-Op. & Org.			1,230	1,230		1,230		1,230			31
32	Interest			30,200	30,200		30,200	3,943	34,143			32
33	Real Estate Taxes			54,131	54,131		54,131	1,917	56,048			33
34	Rent-Facility & Grounds			278,757	278,757		278,757	(15,118)	263,639			34
35	Rent-Equipment & Vehicles			5,808	5,808		5,808	4,501	10,309			35
36	Other (specify):*											36
37	TOTAL Ownership			485,900	485,900		485,900	(110,463)	375,437			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		101,144	262,562	363,706		363,706		363,706			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,108	53,108		53,108		53,108			42
43	Other (specify):*	50,690		171,851	222,541		222,541	(222,541)				43
44	TOTAL Special Cost Centers	50,690	101,144	487,521	639,355		639,355	(222,541)	416,814			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,849,314	375,724	1,959,071	4,184,109		4,184,109	(517,163)	3,666,946			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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,448)	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	(109,499)	30		9
10	Interest and Other Investment Income	(36)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(24)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(815)	21		19
20	Contributions	(100)	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	(63,652)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(120)	20		28
29	Other-Attach Schedule	(221,873)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (399,567)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(117,596)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (117,596)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (517,163)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Rockford Nursing & Rehab Ctr

ID# 0050435

Report Period Beginning: 01/01/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing Salary	\$ (50,690)	43	1
2	Bank Charges	(31,151)	21	2
3	Marketing Expenses	(6,548)	43	3
4	Non-Allowable Legal	(296)	19	4
5	Non-Allowable Professional Fees	(2,500)	19	5
6	Additional R&M	10,915	06	6
7	Non-Allowable Fees	(141,603)	43	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				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	(221,873)		49

Rockford Nursing & Rehab Ctr

ID# 0050435

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 Rockford Nursing & Rehab Ctr# 0050435

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				(5,334)								(5,334)	1
2	Food Purchase	(24)											(24)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,024									1,024	5
6	Maintenance	7,467		2,524		45							10,036	6
7	Other (specify):*			396	941								1,337	7
8	TOTAL General Services	7,443		3,944	(4,393)	45							7,040	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				(12,422)								(12,422)	10
10a	Therapy													10a
11	Activities													11
12	Social Services				176								176	12
13	CNA Training													13
14	Program Transportation				1,968								1,968	14
15	Other (specify):*				3,826								3,826	15
16	TOTAL Health Care and Programs				(6,452)								(6,452)	16
	C. General Administration													
17	Administrative			7,100	(56,176)								(49,076)	17
18	Directors Fees													18
19	Professional Services	(2,796)		(111,100)	(8,580)	1,636							(120,840)	19
20	Fees, Subscriptions & Promotions	(220)		251	46	86							163	20
21	Clerical & General Office Expenses	(95,618)		56,971	6,645	38							(31,964)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			304	600								904	24
25	Other Admin. Staff Transportation			1,275	181								1,457	25
26	Insurance-Prop.Liab.Malpractice			1,201									1,201	26
27	Other (specify):*			11,635	1,773								13,408	27
28	TOTAL General Administration	(98,634)		(32,363)	(55,511)	1,761							(184,747)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(91,191)		(28,419)	(66,355)	1,805							(184,159)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rockford Nursing & Rehab Ctr# 0050435

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

	Capital Expense	PAGES 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	D. Ownership													
	Depreciation	(109,499)		2,942	33	818							(105,706)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(36)		20		3,959							3,943	32
33	Real Estate Taxes			1,821		96							1,917	33
34	Rent-Facility & Grounds			(6,130)		(8,988)							(15,118)	34
35	Rent-Equipment & Vehicles			1,098	3,402								4,501	35
36	Other (specify):*													36
37	TOTAL Ownership	(109,535)		(248)	3,435	(4,115)							(110,463)	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):*	(198,841)			(23,700)								(222,541)	43
44	TOTAL Special Cost Centers	(198,841)			(23,700)								(222,541)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(399,567)		(28,667)	(86,620)	(2,310)							(517,163)	45

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
David Berkowitz	40%	See Attached		See Attached		
Joshua Weinstein	20%					
Yosef Meystel	40%					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	YAM MANAGEMENT, LLC	100.00%	\$ 1,024	\$ 1,024
16	V	6 REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	2,524	2,524
17	V	7 EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	396	396
18	V	17 ADMIN. - RELATED		YAM MANAGEMENT, LLC	100.00%	5,032	5,032
19	V	17 ADMIN. - NON RELATED		YAM MANAGEMENT, LLC	100.00%	2,068	2,068
20	V	19 PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	4,561	4,561
21	V	20 FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	251	251
22	V	21 CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	56,971	56,971
23	V	24 SEMINARS		YAM MANAGEMENT, LLC	100.00%	304	304
24	V	25 AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	1,275	1,275
25	V	26 INSURANCE		YAM MANAGEMENT, LLC	100.00%	1,201	1,201
26	V	27 EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	11,635	11,635
27	V	30 DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	2,942	2,942
28	V	32 INTEREST		YAM MANAGEMENT, LLC	100.00%	20	20
29	V	33 REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%	1,821	1,821
30	V	34 RENT		YAM MANAGEMENT, LLC	100.00%	10,620	10,620
31	V	35 AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	632	632
32	V	35 EQUIPMENT RENTAL		YAM MANAGEMENT, LLC	100.00%	466	466
33	V						
34	V						
35	V	19 BOOKKEEPING FEES	79,661	YAM MANAGEMENT, LLC	100.00%		(79,661)
36	V	19 ACCOUNTING	36,000	YAM MANAGEMENT, LLC	100.00%		(36,000)
37	V	34 RENT	16,750	YAM MANAGEMENT, LLC	100.00%		(16,750)
38	V						
39	Total		\$ 132,411			\$ 103,744	\$ * (28,667)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	<u>1</u> DIETARY	\$	<u>YAM CONSULTING, LLC</u>	100.00%	\$ 8,114	\$	8,114	15
16	V	<u>7</u> EMP. BEN. GEN. SERV.		<u>YAM CONSULTING, LLC</u>	100.00%	941		941	16
17	V	<u>10</u> NURSING SALARY		<u>YAM CONSULTING, LLC</u>	100.00%	30,505		30,505	17
18	V	<u>12</u> SOCIAL SERVICES SALARY		<u>YAM CONSULTING, LLC</u>	100.00%	176		176	18
19	V	<u>14</u> PROGRAM TRANSPORTATION		<u>YAM CONSULTING, LLC</u>	100.00%	1,968		1,968	19
20	V	<u>15</u> EMP. BEN. HEALTHCARE		<u>YAM CONSULTING, LLC</u>	100.00%	3,826		3,826	20
21	V	<u>17</u> ADMIN. - NON RELEATED		<u>YAM CONSULTING, LLC</u>	100.00%	6,224		6,224	21
22	V	<u>19</u> PROFESSIONAL FEES		<u>YAM CONSULTING, LLC</u>	100.00%	156		156	22
23	V	<u>20</u> FEES, SUBSCRIPTIONS		<u>YAM CONSULTING, LLC</u>	100.00%	46		46	23
24	V	<u>21</u> CLERICAL & GENERAL		<u>YAM CONSULTING, LLC</u>	100.00%	6,645		6,645	24
25	V	<u>24</u> SEMINARS		<u>YAM CONSULTING, LLC</u>	100.00%	600		600	25
26	V	<u>25</u> AUTO AND TRAVEL		<u>YAM CONSULTING, LLC</u>	100.00%	181		181	26
27	V	<u>27</u> EMP. BEN.-GEN. ADMIN.		<u>YAM CONSULTING, LLC</u>	100.00%	1,773		1,773	27
28	V	<u>30</u> DEPRECIATION		<u>YAM CONSULTING, LLC</u>	100.00%	33		33	28
29	V	<u>35</u> AUTO RENTAL		<u>YAM CONSULTING, LLC</u>	100.00%	3,402		3,402	29
30	V								30
31	V								31
32	V								32
33	V	<u>1</u> DIETARY CONSULTING	13,448	<u>YAM CONSULTING, LLC</u>				(13,448)	33
34	V	<u>10</u> RN CONSULTING	42,927	<u>YAM CONSULTING, LLC</u>				(42,927)	34
35	V	<u>17</u> DIR. OF OPERATIONS CONSULT	62,400	<u>YAM CONSULTING, LLC</u>				(62,400)	35
36	V	<u>19</u> DATA PROCESSING FEES	8,736	<u>YAM CONSULTING, LLC</u>				(8,736)	36
37	V	<u>43</u> MARKETING	23,700	<u>YAM CONSULTING, LLC</u>				(23,700)	37
38	V								38
39	Total		\$ 151,211			\$ 64,591	\$ *	(86,620)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 REPAIRS & MAINTENANCE	\$	8131 N. MONTICELLO, LLC	100.00%	\$ 45	\$	45	15
16	V	19 PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		1,636		1,636	16
17	V	20 DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		86		86	17
18	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC		38		38	18
19	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC		818		818	19
20	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC		3,959		3,959	20
21	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		1,917		1,917	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34 RENT	8,988	8131 N. MONTICELLO, LLC				(8,988)	26
27	V	33 R/E Taxes	1,821	8131 N. MONTICELLO, LLC				(1,821)	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		\$ 10,809			\$ 8,499	\$ *	(2,310)	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Rockford Nursing & Rehab Ctr # 0050435 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Shareholder	Administrative	40.00%	See Attached	2.4	6.00%	Mgmt. Fees	\$ 11,000	17-3	1
2	David Berkowitz	Shareholder	Administrative	40.00%	See Attached	2.4	6.00%	Mgmt. Fees	18,000	17-3	2
3	Jay Meystel	Relative	Administrative	0.00%	See Attached	1.2	3.00%	Alloc. Sal.	3,480	17-7	3
4	Joel Meystel	Relative	Administrative	0.00%	See Attached	1.2	6.00%	Alloc. Sal.	1,552	17-7	4
5	Joshua Weinstein	Shareholder	Administrative	20.00%	See Attached	2.4	6.00%	Alloc. Sal.	8,292	17-7	5
6	Shimon Meystel	Relative	Clerical	0.00%	See Attached	2.4	6.00%	Alloc. Sal.	824	21-7	6
7											7
8	Where Applicable, The Amounts Reported On This Page Have Been Adjusted From The Actual Costs To Reflect Only Amounts Anticipated To Be Considered Allowable										8
9	By The IL. Department of HFS										9
10											10
11											11
12											12
13								TOTAL	\$ 43,148		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rockford Nursing & Rehab Ctr

0050435

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rockford Nursing & Rehab Ctr

0050435

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

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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	AVAIL. BED DAYS	579,474	16	\$ 16,764	\$ 35,405	\$ 1,024	1	
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	579,474	16	41,306	29,925	35,405	2,524	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	579,474	16	6,478	35,405	396	3	
4	17	ADMIN. - RELATED	AVAIL. BED DAYS	579,474	16	82,362	82,362	35,405	5,032	4
5	17	ADMIN. - NON RELATED	AVAIL. BED DAYS	579,474	16	33,843	33,843	35,405	2,068	5
6	19	PROFESSIONAL FEES	AVAIL. BED DAYS	579,474	16	74,656	35,405	4,561	6	
7	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	579,474	16	4,114	35,405	251	7	
8	21	CLERICAL & GENERAL	AVAIL. BED DAYS	579,474	16	932,452	841,703	35,405	56,971	8
9	24	SEMINARS	AVAIL. BED DAYS	579,474	16	4,974	35,405	304	9	
10	25	AUTO AND TRAVEL	AVAIL. BED DAYS	579,474	16	20,872	35,405	1,275	10	
11	26	INSURANCE	AVAIL. BED DAYS	579,474	16	19,661	35,405	1,201	11	
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	579,474	16	190,434	35,405	11,635	12	
13	30	DEPRECIATION	AVAIL. BED DAYS	579,474	16	48,156	35,405	2,942	13	
14	32	INTEREST	AVAIL. BED DAYS	579,474	16	331	35,405	20	14	
15	33	REAL ESTATE TAX	AVAIL. BED DAYS	579,474	16	29,806	35,405	1,821	15	
16	34	RENT	AVAIL. BED DAYS	579,474	16	173,825	35,405	10,620	16	
17	35	AUTO RENTAL	AVAIL. BED DAYS	579,474	16	10,347	35,405	632	17	
18	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	579,474	16	7,632	35,405	466	18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,698,015	\$ 987,832	\$ 103,744	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rockford Nursing & Rehab Ctr

0050435

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 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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY	AVAIL. BED DAYS	579,474	16	\$ 132,801	\$ 123,648	35,405	\$ 8,114	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	579,474	16	15,402		35,405	941	2
3	10	NURSING SALARY	AVAIL. BED DAYS	579,474	16	499,281	499,281	35,405	30,505	3
4	12	SOCIAL SERVICES SALARY	AVAIL. BED DAYS	579,474	16	2,888	2,888	35,405	176	4
5	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	579,474	16	32,206		35,405	1,968	5
6	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	579,474	16	62,625		35,405	3,826	6
7	17	ADMIN. - NON RELEATED	AVAIL. BED DAYS	579,474	16	101,866	101,866	35,405	6,224	7
8	19	PROFESSIONAL FEES	AVAIL. BED DAYS	579,474	16	2,550		35,405	156	8
9	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	579,474	16	755		35,405	46	9
10	21	CLERICAL & GENERAL	AVAIL. BED DAYS	579,474	16	108,757	86,009	35,405	6,645	10
11	24	SEMINARS	AVAIL. BED DAYS	579,474	16	9,816		35,405	600	11
12	25	AUTO AND TRAVEL	AVAIL. BED DAYS	579,474	16	2,967		35,405	181	12
13	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	579,474	16	29,022		35,405	1,773	13
14	30	DEPRECIATION	AVAIL. BED DAYS	579,474	16	539		35,405	33	14
15	35	AUTO RENTAL	AVAIL. BED DAYS	579,474	16	55,686		35,405	3,402	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		\$ 64,591	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rockford Nursing & Rehab Ctr

0050435

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	579,474	16	\$ 732	\$ 35,405	\$ 45	1
2	19	PROFESSIONAL FEES	AVAIL. BED DAYS	579,474	16	26,780	35,405	1,636	2
3	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	579,474	16	1,405	35,405	86	3
4	21	OFFICE EXPENSE	AVAIL. BED DAYS	579,474	16	630	35,405	38	4
5	30	DEPRECIATION	AVAIL. BED DAYS	579,474	16	13,389	35,405	818	5
6	32	INTEREST EXPENSE	AVAIL. BED DAYS	579,474	16	64,796	35,405	3,959	6
7	33	REAL ESTATE TAXES	AVAIL. BED DAYS	579,474	16	31,375	35,405	1,917	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 139,107	\$	\$ 8,499	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rockford Nursing & Rehab Ctr

0050435

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rockford Nursing & Rehab Ctr

0050435

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rockford Nursing & Rehab Ctr

0050435

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rockford Nursing & Rehab Ctr

0050435

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rockford Nursing & Rehab Ctr

0050435 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rockford Nursing & Rehab Ctr

0050435

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Rockford Nursing & Rehab Ctr

0050435

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**		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										5										
6										6										
7	TOTAL Long-Term																			
Working Capital																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	TOTAL Working Capital																			
B. Non-Facility Related*																				
15										15										
16										16										
17										17										
18										18										
19										19										
20	TOTAL Non-Facility Related																			

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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 Rockford Nursing & Rehab Ctr COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0050435

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)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
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 Rockford Nursing & Rehab Ctr

0050435

Report Period Beginning:

01/01/10

Ending:

12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 58,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2

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

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

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

None

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

1. Total Amount Incurred: 4,920 2. Number of Years Over Which it is Being Amortized: 1 (12 Months)
3. Current Period Amortization: 1,230 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Rockford Nursing & Rehab Ctr**

0050435

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

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

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68			77,173	840	1,226	386	1,344	68
69				115,773		(115,773)		69
70			\$ 77,173	\$ 116,613	\$ 1,226	\$ (115,387)	\$ 1,344	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 77,173	\$ 116,613		\$ 1,226	\$ (115,387)	\$ 1,344	1
2	Drop Ceiling / Lighting	2008	5,060		20	253	253	590	2
3	Air Conditioner / Water Heater	2009	4,468		20	223	223	372	3
4	Hd Receivers / Dish / Camera System / Wiring	2009	3,825		20	191	191	239	4
5	Water Heater	2009	6,350		20	318	318	344	5
6	Hot Water System / Boiler	2009	5,524		20	276	276	368	6
7	Camera / Cable	2009	9,174		20	459	459	803	7
8	Front Door Entrance Alarm	2009	2,710		20	136	136	226	8
9	Headend Hardware & Installation	2009	6,200		20	310	310	439	9
10	Wiring For Camera / Dish	2009	2,650		20	133	133	166	10
11	Camera / Cable	2009	3,319		20	166	166	194	11
12	Smoke Detectors / Sprinkler Heads	2009	3,060		20	153	153	179	12
13	Water Heater	2010	6,100		20	508	508	508	13
14	Condensate Pump	2010	4,745		20	158	158	158	14
15	Flooring/ Ceiling/ Wallcovering	2010	58,456		20	1,947	1,947	1,947	15
16	Drop Ceiling/ Lighting	2010	6,611		20	220	220	220	16
17	100 Gallon Gas Water Heater	2010	7,084		20	354	354	354	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)		\$ 212,508	\$ 116,613		\$ 7,030	\$ (109,583)	\$ 8,451	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 212,508	\$ 116,613		\$ 7,030	\$ (109,583)	\$ 8,451	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 212,508	\$ 116,613		\$ 7,030	\$ (109,583)	\$ 8,451	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 212,508	\$ 116,613		\$ 7,030	\$ (109,583)	\$ 8,451	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 212,508	\$ 116,613		\$ 7,030	\$ (109,583)	\$ 8,451	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 212,508	\$ 116,613		\$ 7,030	\$ (109,583)	\$ 8,451	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 212,508	\$ 116,613		\$ 7,030	\$ (109,583)	\$ 8,451	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

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

Building Company Information Continued

TOTAL (12F & 12G lines 1 thru 33)

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	<u>Allocated From 8131 N. Monticello, LLC</u>	<u>2010</u>	<u>54,440</u>	<u>577</u>	<u>35</u>	<u>576</u>	<u>(1)</u>	<u>576</u>	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	<u>Allocated From YAM Management, LLC</u>	<u>2007</u>	<u>1,307</u>	<u>4</u>	<u>20</u>	<u>65</u>	<u>61</u>	<u>204</u>	9
10	<u>Allocated From YAM Management, LLC</u>	<u>2008</u>	<u>90</u>	<u>1</u>	<u>20</u>	<u>4</u>	<u>3</u>		10
11	<u>Allocated From YAM Management, LLC</u>	<u>2009</u>	<u>397</u>	<u>5</u>	<u>20</u>	<u>17</u>	<u>12</u>		11
12	<u>Allocated From YAM Management, LLC</u>	<u>2010</u>	<u>2,013</u>	<u>12</u>	<u>20</u>	<u>55</u>	<u>43</u>	<u>55</u>	12
13									13
14	<u>Allocated From 8131 N. Monticello, LLC</u>	<u>2010</u>	<u>18,926</u>	<u>241</u>	<u>20</u>	<u>509</u>	<u>268</u>	<u>509</u>	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
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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									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)	\$ 77,173	\$ 840		\$ 1,226	\$ 386	\$ 1,344	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Rockford Nursing & Rehab Ctr**

0050435

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	\$ 6,398	\$ 843	\$ 1,254	\$ 411	10	\$ 2,574	71
72	Current Year Purchases	17,859	1,945	1,524	(421)	10	1,524	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 24,257	\$ 2,788	\$ 2,778	\$ (10)		\$ 4,098	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated From YAM Mgmt	2009	\$ 1,444	\$ 165	\$ 258	\$ 93	5	\$ 842	76
77										77
78										78
79										79
80	TOTALS			\$ 1,444	\$ 165	\$ 258	\$ 93		\$ 842	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)	\$ 238,209	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 119,566	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 10,067	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (109,499)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 13,391	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: North Main Properties, LLC

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

If NO, see instructions. YES NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>97</u>		\$ <u>262,007</u>			3
4	Additions						4
5	<u>Alloc. From YAM Mgmt</u>			<u>1,632</u>			5
6							6
7	TOTAL	97		\$ 263,639			7

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

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

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

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: \$ 6,274 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Alloc. From YAM Mgmt</u>		\$ _____	\$ <u>632</u>	17
18	<u>Alloc. From YAM Consult.</u>			<u>3,402</u>	18
19					19
20					20
21	TOTAL		\$ _____	\$ 4,034	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2011 \$ _____

13. _____/2012 \$ _____

14. _____/2013 \$ _____

* 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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	116,145	\$		\$	116,145	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				12,908				12,908	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				133,509				133,509	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescrpts					98,853			98,853	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <u>See Supplemental</u>							2,291			2,291	13
14	TOTAL			\$		\$	262,562	\$	101,144	\$	363,706	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rockford Nursing & Rehab Ctr# 0050435Report Period Beginning: 01/01/10Ending: 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	\$ 1,000	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	819,416		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,073		6
7	Other Prepaid Expenses	276		7
8	Accounts Receivable (owners or related parties)	67,500		8
9	Other(specify): <u>See Attached Schedule</u>	190,553		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,107,818	\$	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	114,618		15
16	Equipment, at Historical Cost	61,731		16
17	Accumulated Depreciation (book methods)	(119,502)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 56,847	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,164,665	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 656,674	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,972		28
29	Short-Term Notes Payable	350,000		29
30	Accrued Salaries Payable	85,839		30
31	Accrued Taxes Payable (excluding real estate taxes)	(1,306)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	55,417		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	532,968		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,681,564	\$	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	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,681,564	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (516,899)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,164,665	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (321,770)	1
2	Restatements (describe):		2
3	Members Capital Adjustment	(112,500)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (434,270)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(349,504)	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	(18,125)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Member's Capital	285,000	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (82,629)	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)	\$ (516,899)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Rockford Nursing & Rehab Ctr**# **0050435**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.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,258,663	1
2	Discounts and Allowances for all Levels	(120,387)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,138,276	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	584,643	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 584,643	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	87,532	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,484	19
20	Radiology and X-Ray	2,448	20
21	Other Medical Services	10,186	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 111,650	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	36	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 36	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,834,605	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	701,567	31
32	Health Care	1,488,102	32
33	General Administration	869,185	33
B. Capital Expense			
34	Ownership	485,900	34
C. Ancillary Expense			
35	Special Cost Centers	586,247	35
36	Provider Participation Fee	53,108	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,184,109	40
41	Income before Income Taxes (line 30 minus line 40)**	(349,504)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (349,504)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? not complete 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 **Rockford Nursing & Rehab Ctr**

0050435

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	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,985	2,129	\$ 77,651	\$ 36.47	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,745	8,130	222,494	27.37	3
4	Licensed Practical Nurses	14,839	15,437	385,913	25.00	4
5	CNAs & Orderlies	41,506	43,742	485,160	11.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,495	1,574	17,468	11.10	8
9	Activity Director	1,949	2,089	19,869	9.51	9
10	Activity Assistants	3,839	3,971	34,489	8.69	10
11	Social Service Workers	2,001	2,086	42,111	20.19	11
12	Dietician					12
13	Food Service Supervisor	2,001	2,086	29,596	14.19	13
14	Head Cook	5,351	5,760	70,890	12.31	14
15	Cook Helpers/Assistants	6,497	6,959	63,667	9.15	15
16	Dishwashers					16
17	Maintenance Workers	4,200	4,475	69,171	15.46	17
18	Housekeepers	5,539	6,026	59,450	9.87	18
19	Laundry	5,415	5,730	50,585	8.83	19
20	Administrator	1,497	1,613	82,872	51.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,244	5,535	57,600	10.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,283	1,376	29,638	21.54	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,929	2,081	50,690	24.36	33
34	TOTAL (lines 1 - 33)	114,315	120,799	\$ 1,849,314 *	\$ 15.31	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	267	\$ 13,448	01-03	35
36	Medical Director	Monthly	13,690	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	607	42,927	10-03	38
39	Pharmacist Consultant	Monthly	3,764	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				44
45	Social Service Consultant	91	5,013	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	965	\$ 78,842		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Gregory Taylor	Administrator	0.00%	\$ 82,872	Workers' Compensation Insurance	\$ 35,217	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	54,012	Advertising: Employee Recruitment	825	
				FICA Taxes	136,056	Health Care Worker Background Check	2,398	
				Employee Health Insurance	45,804	(Indicate # of checks performed <u>240</u>)		
				Employee Meals	12,319	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	1,030	
				Employee Welfare	890	Licenses & Fees	3,595	
				401K / Pension	10,746	Yellow Page Advertising	120	
				Physical Exams	270			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 82,872	TOTAL (agree to Schedule V, line 22, col.8)		\$ 9,226		
B. Administrative - Other							See Supplemental Schedule	
Description			Amount				Less: Public Relations Expense ()	
Yam Consulting - Administrative Consulting			\$ 62,400				Non-allowable advertising ()	
Yosef Meystel - Management Fee			11,000				Yellow page advertising (120)	
David Berkowitz - Management Fee			18,000				TOTAL (agree to Sch. V, line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 91,400				\$ 9,226	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
YAM Management	Bookkeeping		\$ 79,661				Out-of-State Travel	\$
YAM Management	Accounting		36,000					
Frost, Ruttenberg & Rothblatt	Accounting		10,500				In-State Travel	
Personnel Planners, Inc	Unemployment Consulting		1,325					
YAM Consulting	Data Processing		8,736				Seminar Expense	25
American Data	Data Processing		4,737				Allocated From YAM Management	304
Health Data Systems, Inc.	Data Processing		4,817				Allocated from YAM Consulting	600
Micro Works Computer Center	Data Processing		357					
Dgtell	Data Processing		450				Entertainment Expense ()	
E-Health Data Solutions	Data Processing		4,524				(agree to Sch. V, line 24, col. 8)	
Adj. on Page 5a	Legal		296				TOTAL	\$ 929
See Supplemental Schedule			12,587					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 163,990	TOTAL				

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	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 Rockford Nursing & Rehab Ctr# 0050435Report Period Beginning: 01/01/10Ending: 12/31/10**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,266 Line 10-02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? 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. \$ 53,108
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. \$ 12,319 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln14
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.