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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0048454

Facility Name: Evanston Nursing & Rehab Center

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 09/01/06

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 01/01/11 to 12/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,954	331	3,282	19,567	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,954	331	3,282	19,567	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.05%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 57 and days of care provided 1,888

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	122,757	8,711	10,863	142,331		142,331	(6,844)	135,487			1
2	Food Purchase		90,674		90,674	(20,148)	70,526	(15)	70,511			2
3	Housekeeping	51,125	6,957		58,082		58,082		58,082			3
4	Laundry	19,691	5,414		25,105		25,105		25,105			4
5	Heat and Other Utilities			57,355	57,355		57,355	(6,056)	51,299			5
6	Maintenance	34,192	10,001	40,325	84,518		84,518	9,805	94,323			6
7	Other (specify):*							536	536			7
8	TOTAL General Services	227,765	121,757	108,543	458,065	(20,148)	437,917	(2,574)	435,343			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	922,377	50,578	19,889	992,844		992,844	1,001	993,845			10
10a	Therapy											10a
11	Activities	44,413	2,885	1,924	49,222		49,222		49,222			11
12	Social Services	37,533		1,468	39,001		39,001		39,001			12
13	CNA Training											13
14	Program Transportation			1,130	1,130		1,130	1,161	2,291			14
15	Other (specify):*							2,253	2,253			15
16	TOTAL Health Care and Programs	1,004,323	53,463	36,411	1,094,197		1,094,197	4,415	1,098,612			16
	C. General Administration											
17	Administrative	80,591		22,950	103,541		103,541	8,793	112,334			17
18	Directors Fees											18
19	Professional Services			128,811	128,811	(500)	128,311	(97,560)	30,751			19
20	Dues, Fees, Subscriptions & Promotions			37,969	37,969		37,969	(23,740)	14,229			20
21	Clerical & General Office Expenses	23,419	12	84,853	108,284		108,284	(26,783)	81,501			21
22	Employee Benefits & Payroll Taxes			250,682	250,682	20,148	270,830		270,830			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,384	2,384		2,384	424	2,808			24
25	Other Admin. Staff Transportation			401	401		401	1,061	1,462			25
26	Insurance-Prop.Liab.Malpractice			59,590	59,590		59,590	641	60,231			26
27	Other (specify):*							8,070	8,070			27
28	TOTAL General Administration	104,010	12	587,640	691,662	19,648	711,310	(129,094)	582,216			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,336,098	175,232	732,594	2,243,924	(500)	2,243,424	(127,253)	2,116,171			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evanston Nursing & Rehab Center #0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			70,445	70,445		70,445	12,457	82,902			30
31	Amortization of Pre-Op. & Org.							0	0			31
32	Interest			20,113	20,113		20,113	192,339	212,452			32
33	Real Estate Taxes			144,099	144,099	500	144,599	6,709	151,308			33
34	Rent-Facility & Grounds			276,900	276,900		276,900	(275,900)	1,000			34
35	Rent-Equipment & Vehicles			1,129	1,129		1,129	2,618	3,747			35
36	Other (specify):*											36
37	**TOTAL Ownership**			512,686	512,686	500	513,186	(61,776)	451,410			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		58,979	265,326	324,305		324,305		324,305			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			31,208	31,208		31,208		31,208			42
43	Other (specify):*			189,649	189,649		189,649	(189,649)				43
44	**TOTAL Special Cost Centers**		58,979	486,183	545,162		545,162	(189,649)	355,513			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,336,098	234,211	1,731,463	3,301,772		3,301,772	(378,678)	2,923,094			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 Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	(6,517)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(26,278)	30		9
10	Interest and Other Investment Income	(1,896)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(15)	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	(1,024)	21		18
19	Entertainment	(3,291)	21		19
20	Contributions	(21,850)	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	(34,483)	21		24
25	Fund Raising, Advertising and Promotional	(734)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,349)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(202,722)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (305,159)		$	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)	(73,519)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (73,519)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (378,678)		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

Evanston Nursing & Rehab Center

ID# 0048454

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	COPE Dues	$ (1,400)	20	1
2	Marketing	(21,800)	43	2
3	Bank Charges	(8,026)	21	3
4	Non-Allowable Fees	(153,349)	43	4
5	Other Unclassified Income	(3,867)	21	5
6	Building Company - Amortization	(16,044)	31	6
7	Building Company - Bank Charges	(266)	21	7
8	Building Company - State Replacement Tax	(12)	21	8
9	Building Company - Accounting Fees	(1,500)	19	9
10	Building Company - Licenses and Fees	(275)	20	10
11	Additional R&M	9,022	06	11
12	Non-Allowable Legal	(5,206)	19	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**	(202,722)		49

Evanston Nursing & Rehab Center

ID# 0048454

Report Period Beginning: 01/01/11

Ending: 12/31/11

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(6,844)								(6,844)	1
2	Food Purchase	(15)											(15)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(6,517)		461									(6,056)	5
6	Maintenance	9,022		783									9,805	6
7	Other (specify):*			55	481								536	7
8	**TOTAL General Services**	2,490		1,299	(6,363)								(2,574)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				1,001								1,001	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation				1,161								1,161	14
15	Other (specify):*				2,253								2,253	15
16	**TOTAL Health Care and Programs**				4,415								4,415	16
	C. General Administration													
17	Administrative			10,806	(2,013)								8,793	17
18	Directors Fees													18
19	Professional Services	(6,706)	1,500	(88,949)	(3,562)	157							(97,560)	19
20	Fees, Subscriptions & Promotions	(24,259)	275	199	26	19							(23,740)	20
21	Clerical & General Office Expenses	(57,318)	278	26,981	3,246	30							(26,783)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			307	117								424	24
25	Other Admin. Staff Transportation			894	167								1,061	25
26	Insurance-Prop.Liab.Malpractice			641									641	26
27	Other (specify):*			7,152	918								8,070	27
28	**TOTAL General Administration**	(88,283)	2,053	(41,969)	(1,101)	206							(129,094)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(85,793)	2,053	(40,670)	(3,049)	206							(127,253)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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	(26,278)	36,651	503	20	1,561							12,457	30
31	Amortization of Pre-Op. & Org.	(16,044)	16,044										0	31
32	Interest	(1,896)	192,536	30		1,669							192,339	32
33	Real Estate Taxes		5,829	1,406		(526)							6,709	33
34	Rent-Facility & Grounds		(259,000)	(12,175)		(4,725)							(275,900)	34
35	Rent-Equipment & Vehicles			742	1,876								2,618	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(44,217)	(7,940)	(9,494)	1,896	(2,021)							(61,776)	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):*	(175,149)			(14,500)								(189,649)	43
44	**TOTAL Special Cost Centers**	(175,149)			(14,500)								(189,649)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(305,159)	(5,887)	(50,164)	(15,653)	(1,815)							(378,678)	45

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent - Base Rent	$ 260,000	Evanston NRC Realty, LLC		$	$ (260,000)	1
2	V	33	Rent - Real Estate Tax	144,099	Evanston NRC Realty, LLC			(144,099)	2
3	V	32	Interest Income	21,336	Evanston NRC Realty, LLC			(21,336)	3
4	V	31	Amortization - Loan Fees		Evanston NRC Realty, LLC		16,044	16,044	4
5	V	21	Bank Charges		Evanston NRC Realty, LLC		266	266	5
6	V	30	Depreciation		Evanston NRC Realty, LLC		36,651	36,651	6
7	V	32	Interest Expense		Evanston NRC Realty, LLC		213,872	213,872	7
8	V	34	Rent		Evanston NRC Realty, LLC		1,000	1,000	8
9	V	33	Taxes - Real Estate		Evanston NRC Realty, LLC		111,808	111,808	9
10	V	33	Taxes - Real Estate - Prior Year		Evanston NRC Realty, LLC		38,120	38,120	10
11	V	21	Taxes - State Replacement Tax		Evanston NRC Realty, LLC		12	12	11
12	V	19	Accounting Fees		Evanston NRC Realty, LLC		1,500	1,500	12
13	V	20	Licenses and Fees		Evanston NRC Realty, LLC		275	275	13
14	Total			$ 425,435			$ 419,548	$ * (5,887)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

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%	$ 461	$ 461	15
16	V	6	REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	783	783	16
17	V	7	EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	55	55	17
18	V	17	ADMINISTRATIVE		YAM MANAGEMENT, LLC	100.00%	10,806	10,806	18
19	V	19	PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	807	807	19
20	V	20	FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	199	199	20
21	V	21	CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	26,981	26,981	21
22	V	24	SEMINARS		YAM MANAGEMENT, LLC	100.00%	307	307	22
23	V	25	AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	894	894	23
24	V	26	INSURANCE		YAM MANAGEMENT, LLC	100.00%	641	641	24
25	V	27	EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	7,152	7,152	25
26	V	30	DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	503	503	26
27	V	32	INTEREST		YAM MANAGEMENT, LLC	100.00%	30	30	27
28	V	33	REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%	1,406	1,406	28
29	V	34	RENT		YAM MANAGEMENT, LLC	100.00%	4,725	4,725	29
30	V	35	AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	548	548	30
31	V	35	EQUIPMENT RENTAL		YAM MANAGEMENT, LLC	100.00%	194	194	31
32	V				YAM MANAGEMENT, LLC	100.00%			32
33	V								33
34	V	19	DATA PROCESSING	856				(856)	34
35	V	19	BOOKKEEPING FEES	52,900	YAM MANAGEMENT, LLC	100.00%		(52,900)	35
36	V	19	ACCOUNTING	36,000	YAM MANAGEMENT, LLC	100.00%		(36,000)	36
37	V	34	RENT	16,900	YAM MANAGEMENT, LLC	100.00%		(16,900)	37
38	V								38
39	Total			$ 106,656			$ 56,492	$ * (50,164)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

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%	$ 4,019	$ 4,019	15
16	V	7	EMP. BEN. GEN. SERV.		YAM CONSULTING, LLC	100.00%	481	481	16
17	V	10	NURSING SALARY		YAM CONSULTING, LLC	100.00%	18,101	18,101	17
18	V	14	PROGRAM TRANSPORTATION		YAM CONSULTING, LLC	100.00%	1,161	1,161	18
19	V	15	EMP. BEN. HEALTHCARE		YAM CONSULTING, LLC	100.00%	2,253	2,253	19
20	V	17	ADMINISTRATIVE		YAM CONSULTING, LLC	100.00%	5,937	5,937	20
21	V	19	PROFESSIONAL FEES		YAM CONSULTING, LLC	100.00%	1,574	1,574	21
22	V	20	FEES, SUBSCRIPTIONS		YAM CONSULTING, LLC	100.00%	26	26	22
23	V	21	CLERICAL & GENERAL		YAM CONSULTING, LLC	100.00%	3,246	3,246	23
24	V	24	SEMINARS		YAM CONSULTING, LLC	100.00%	117	117	24
25	V	25	AUTO AND TRAVEL		YAM CONSULTING, LLC	100.00%	167	167	25
26	V	27	EMP. BEN.-GEN. ADMIN.		YAM CONSULTING, LLC	100.00%	918	918	26
27	V	30	DEPRECIATION		YAM CONSULTING, LLC	100.00%	20	20	27
28	V	35	AUTO RENTAL		YAM CONSULTING, LLC	100.00%	1,876	1,876	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V	1	DIETICIAN CONSULTING	10,863	YAM CONSULTING, LLC	100.00%		(10,863)	33
34	V	10	NURSE CONSULTING	17,100	YAM CONSULTING, LLC	100.00%		(17,100)	34
35	V	17	DIR. OF OPERATIONS CONSULT	7,950	YAM CONSULTING, LLC	100.00%		(7,950)	35
36	V	19	DATA PROCESSING FEES	5,136	YAM CONSULTING, LLC	100.00%		(5,136)	36
37	V	43	MARKETING	14,500	YAM CONSULTING, LLC	100.00%		(14,500)	37
38	V								38
39	Total			$ 55,549			$ 39,896	$ * (15,653)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	19	PROFESSIONAL FEES	$	8131 N. MONTICELLO, LLC	100.00%	$ 157	$ 157	15
16	V	20	DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		19	19	16
17	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		30	30	17
18	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		1,561	1,561	18
19	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		1,669	1,669	19
20	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		880	880	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	4,725	8131 N. MONTICELLO, LLC			(4,725)	26
27	V	33	REAL ESTATE TAXES	1,406	8131 N. MONTICELLO, LLC			(1,406)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 6,131			$ 4,316	$ * (1,815)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	1219 LIMITED PARTNERSHIP	7.500%	BERKSHIRE NURSING & REHAB CENTER,LLC	FOREST PARK	EVANSTON NRC REALTY, LLC	SKOKIE	BUILDING CO.	1
2	257 LIMITED PARTNERSHIP	7.500%	CONCORD NURSING AND REHABILITATION CENTER,LLC	OAK LAWN	YAM MANAGEMENT	SKOKIE	MANAGEMENT CO.	2
3	42170 LIMITED PARTNERSHIP	7.500%	DOLTON NURSING & REHAB,LLC	DOLTON	YAM CONSULTING	SKOKIE	CONSULTING CO.	3
4	BARRY ROSEBLUM	2.500%	EXCEPTIONAL CARE, LLC	BURBANK	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDIN	4
5	DAVID KLEINER	3.750%	FAIRVIEW CARE CENTER OF JOLIET,LLC	JOLIET				5
6	DENNIS RUBEN	3.500%	HIGHLAND PARK NURSING AND REHAB CENTER, LLC	HIGHWOOD				6
7	GARY BIDER	3.750%	INTERNATIONAL NURSING & REHAB CENTER,LLC	CHICAGO				7
8	JOYCE RUBEN	3.500%	JACKSONVILLE CARE CENTER	JACKSONVILLE				8
9	LAURA RUBEN	1.500%	LITCHFIELD CARE CENTER,LLC	LITCHFIELD				9
10	MARLEE ASSOCIATES, LLC	4.250%	NORTH CHURCH NURSING & REHAB,LLC	JACKSONVILLE				10
11	MICHAEL ROSEN	2.000%	PLAZA NURSING AND REHAB CENTER,LLC	MIDLOTHIAN				11
12	MOSHE EPSTEIN	0.750%	PLUM GROVE NURSING AND REHAB,LLC	PALATINE				12
13	RACHEL ESFORMES	4.750%	RIVIERA CARE CENTER,LLC	CHICAGO HEIGHTS				13
14	REBECCA LAFER	3.000%	ROCKFORD NUR. & REHAB	ROCKFORD				14
15	SERENA ESFORMES	2.500%	SPRINGFIELD CARE CENTER,LLC	SPRINGFIELD				15
16	YOSEF MEYSTEL	40.250%						16
17	ZAXHARY RUBEN	1.500%						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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

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

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Owner	Administrative	40.25%	See Attached	1.2	3.00%	Mgmt. Fees	$ 15,000	17-03	1
2	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.6	1.50%	Alloc. Salary	1,833	17-07	2
3	Joel Meystel	Relative	Administrative	0.00%	See Attached	0.6	3.00%	Alloc. Salary	698	17-07	3
4											4
5											5
6											6
7											7
8											8
9	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										9
10	anticipated to be considered allowable by the IL. Dept. of HFS.										10
11											11
12											12
13								TOTAL	$ 17,531		13

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

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	686,836	17	$ 15,204	$	20,805	$ 461	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	686,836	17	25,846	8,238	20,805	783	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	686,836	17	1,829		20,805	55	3
4	17	ADMINISTRATIVE	AVAIL. BED DAYS	686,836	17	356,736	356,736	20,805	10,806	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	26,635		20,805	807	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	6,564		20,805	199	6
7	21	CLERICAL & GENERAL	AVAIL. BED DAYS	686,836	17	890,719	835,933	20,805	26,981	7
8	24	SEMINARS	AVAIL. BED DAYS	686,836	17	10,148		20,805	307	8
9	25	AUTO AND TRAVEL	AVAIL. BED DAYS	686,836	17	29,510		20,805	894	9
10	26	INSURANCE	AVAIL. BED DAYS	686,836	17	21,145		20,805	641	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	686,836	17	236,117		20,805	7,152	11
12	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	16,611		20,805	503	12
13	32	INTEREST	AVAIL. BED DAYS	686,836	17	1,006		20,805	30	13
14	33	REAL ESTATE TAX	AVAIL. BED DAYS	686,836	17	46,424		20,805	1,406	14
15	34	RENT	AVAIL. BED DAYS	686,836	17	156,000		20,805	4,725	15
16	35	AUTO RENTAL	AVAIL. BED DAYS	686,836	17	18,091		20,805	548	16
17	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	686,836	17	6,400		20,805	194	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,864,985	$ 1,200,907		$ 56,492	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	1	DIETARY	AVAIL. BED DAYS	686,836	17	$ 132,684	$ 123,698	20,805	$ 4,019	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	686,836	17	15,896		20,805	481	2
3	10	NURSING SALARY	AVAIL. BED DAYS	686,836	17	597,577	597,577	20,805	18,101	3
4	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	686,836	17	38,325		20,805	1,161	4
5	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	686,836	17	74,394		20,805	2,253	5
6	17	ADMINISTRATIVE	AVAIL. BED DAYS	686,836	17	195,987	195,987	20,805	5,937	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	51,975		20,805	1,574	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	849		20,805	26	8
9	21	CLERICAL & GENERAL	AVAIL. BED DAYS	686,836	17	107,160	91,547	20,805	3,246	9
10	24	SEMINARS	AVAIL. BED DAYS	686,836	17	3,858		20,805	117	10
11	25	AUTO AND TRAVEL	AVAIL. BED DAYS	686,836	17	5,508		20,805	167	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	686,836	17	30,309		20,805	918	12
13	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	673		20,805	20	13
14	35	AUTO RENTAL	AVAIL. BED DAYS	686,836	17	61,921		20,805	1,876	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,317,116	$ 1,008,809		$ 39,896	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	$ 5,168	$	20,805	$ 157	1
2	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	624		20,805	19	2
3	21	OFFICE EXPENSE	AVAIL. BED DAYS	686,836	17	1,000		20,805	30	3
4	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	51,542		20,805	1,561	4
5	32	INTEREST EXPENSE	AVAIL. BED DAYS	686,836	17	55,103		20,805	1,669	5
6	33	REAL ESTATE TAXES	AVAIL. BED DAYS	686,836	17	29,058		20,805	880	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					$ 142,495	$		$ 4,316	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5	See Supplemental Schedule							4,000,000			213,872	5
	Working Capital											
6	Lake Forest Bank & Trust Co.		X	Line of Credit				550,000			19,143	6
7	Insurance Policies		X								970	7
8	See Supplemental Schedule										1,699	8
9	TOTAL Facility Related						$	$ 4,550,000			$ 235,684	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,896)	10
11												11
12												12
13	See Supplemental Schedule										(21,336)	13
14	TOTAL Non-Facility Related						$	$			$ (23,232)	14
15	TOTALS (line 9+line14)						$	$ 4,550,000			$ 212,452	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	Bldg Co. - Mortgage Payable		X	Mortgage			$	$ 2,037,688			$ 140,176	1
2	Bldg Co. - Mortgage Payable		X	Mortgage				1,962,312			73,696	2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term							4,000,000			213,872	7
	Working Capital											
8	Allocated from Yam Mgmnt		X				$	$			$ 30	8
9	Allocated from 8131 N. Monticello		X								1,669	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										1,699	14
	B. Non-Facility Related*											
15	Bldg Co. - Interest Income		X				$	$			$ (21,336)	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										(21,336)	20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 73,689	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.)		$ 112,688	2
3. Under or (over) accrual (line 2 minus line 1).		$ 38,999	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 111,808	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.**		$ 500	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.		$ 151,307	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	113,628	8
	2007	100,729	9
	2008	104,597	10
	2009	73,669	11
	2010	111,808	12

2011 Accrual - 2010 R/E Tax
Allocated from 8131 N. Monticello - $955

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Evanston Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048454

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-18-326-011-0000	Long Term Care Property	$ 111,808.03	$ 111,808.03
2.	10-23-325-045-0000	Allocated from Mgmt Co.	$ 35,987.49	$ 954.91
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 147,795.52	$ 112,762.94

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

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Evanston Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048454

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			2008	$ 286,895	1
2	Allocated from 8131 N. Monticello			2,696	2
3	TOTALS			$ 289,591	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	57			1961	$ 1,644,650	$ 19,606	35	$	$ (19,606)	$ 83,777	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2007	57,689		20	3,847	3,847	29,251	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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)		31,328	1,661		1,106	(555)	1,632	68
69	Financial Statement Depreciation			70,445			(70,445)		69
70	TOTAL (lines 4 thru 69)		$ 1,733,667	$ 91,712		$ 4,953	$ (86,759)	$ 114,660	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,733,667	$ 91,712		$ 4,953	$ (86,759)	$ 114,660	1
2	Kitchen Floor, Shower Room And Plumbing	2008	5,550		20	555	555	2,174	2
3	2Nd Floor Outside Patio Work	2008	32,262		20	3,226	3,226	11,292	3
4	Electrical Work	2008	4,100		20	410	410	1,367	4
5	2Nd Floor Porch	2008	6,876		20	688	688	2,407	5
6	2Nd Floor Nurses Station	2008	14,300		20	1,430	1,430	5,124	6
7	Cornice, Cubicle Curtains, Bed Quilts	2008	7,865		20	787	787	2,622	7
8	Handrails, Bumpers, Wallcoverings, Etc	2008	25,009		20	2,501	2,501	8,128	8
9	Fireplace And Light Installation	2009	4,550		20	455	455	1,289	9
10	Window Treatments; Cubicle Curtains; Chair	2009	15,559		20	1,556	1,556	4,149	10
11	Flooring Sealant, Carpet Removal, New Hardwood Floor	2009	6,900		20	690	690	1,610	11
12	Ground Floor Washroom- Floor And Wall Tiles, Grab Bars	2009	4,425		20	443	443	1,106	12
13	1St & 2Nd Flr Bathrooms- Floor Tiles, Electrical, Paint	2009	17,200		20	1,720	1,720	3,870	13
14	New Elevator Equipment	2009	9,966		20	997	997	2,242	14
15	Acm Elevator	2010	4,415		20	221	221	442	15
16	Window Treatment	2010	3,104		20	621	621	1,242	16
17	Bathrooms - Fixtures, Tile, Flooring, Door, Paint, Lights	2010	16,000		20	800	800	1,600	17
18	Bathrooms - Fixtures, Tile, Flooring, Door, Paint, Lights	2010	4,000		20	200	200	400	18
19	Bathrooms - Fixtures, Tile, Flooring, Door, Paint, Lights	2010	4,000		20	200	200	400	19
20	Bathrooms - Fixtures, Tile, Flooring, Door, Paint, Lights	2010	4,000		20	200	200	383	20
21	Flooring Office	2010	3,121		20	624	624	1,196	21
22	Bathrooms - Fixtures, Tile, Flooring, Door, Paint, Lights	2010	5,256		20	263	263	460	22
23	Light Installation	2010	7,445		20	372	372	558	23
24	Living Room Tile	2010	9,854		20	493	493	657	24
25	Overbed Lighting	2010	3,632		20	726	726	1,089	25
26	Built-In Dresser, Cover Lights, Granite Tops, Locks & Installation	2010	31,000		20	2,067	2,067	2,067	26
27	Repair And Paint Walls, Handrails	2010	3,420		20	242	242	242	27
28	Plumbing	2010	4,651		20	388	388	388	28
29	Elevator Paint, Handrail	2011	3,800		20	190	190	190	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,995,926	$ 91,712		$ 28,015	$ (63,697)	$ 173,353	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,995,926	$ 91,712		$ 28,015	$ (63,697)	$ 173,353	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)		$ 1,995,926	$ 91,712		$ 28,015	$ (63,697)	$ 173,353	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,995,926	$ 91,712		$ 28,015	$ (63,697)	$ 173,353	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)		$ 1,995,926	$ 91,712		$ 28,015	$ (63,697)	$ 173,353	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 1,995,926	$ 91,712		$ 28,015	$ (63,697)	$ 173,353	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)		$ 1,995,926	$ 91,712		$ 28,015	$ (63,697)	$ 173,353	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 8131 N. Monticello, LLC	2010	20,947	623	39	537	(86)	783	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from 8131 N. Monticello, LLC	2010	9,383	938	20	469	(469)	722	9
10									10
11	Allocated from YAM Management, LLC	2010	998	100	20	100		127	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 31,328	$ 1,661		$ 1,106	$ (555)	$ 1,632	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 433,090	$ 17,375	$ 53,869	$ 36,494	10	$ 194,475	71
72	Current Year Purchases	20,159	3	928	925	10	928	72
73	Fully Depreciated Assets	1,388				10	1,388	73
74								74
75	TOTALS	$ 454,637	$ 17,378	$ 54,797	$ 37,419		$ 196,791	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Yam Mgmnt.	2009	$ 815	$ 90	$ 90	$	5	$ 30	76
77										77
78										78
79										79
80	TOTALS			$ 815	$ 90	$ 90	$		$ 30	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,740,969	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 109,180	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 82,902	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (26,278)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 370,174	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from YAM				1,000			5
6								6
7	TOTAL				$ 1,000 **			7

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

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	$
13.	/2013	$
14.	/2014	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 1,322 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from YAM Management		$	$ 548	17
18	Allocated from YAM Consulting			1,876	18
19					19
20					20
21	TOTAL		$	$ 2,424	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 96,330	$		$ 96,330	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			47,580			47,580	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			121,416			121,416	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				56,928		56,928	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						2,051		2,051	13
14	TOTAL			$		$ 265,326	$ 58,979		$ 324,305	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11 (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	$ (34,959)	$ 2,000,516	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	745,538	745,538	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	60,546	60,546	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	435,448	435,448	8
9	Other(specify): See Attached Schedule	45,421	1,035,377	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,251,994	$ 4,277,425	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		286,895	13
14	Buildings, at Historical Cost		764,650	14
15	Leasehold Improvements, at Historical Cost	292,459	292,459	15
16	Equipment, at Historical Cost	243,803	516,741	16
17	Accumulated Depreciation (book methods)	(203,012)	(509,315)	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	885,500	931,729	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,218,750	$ 2,283,159	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,470,744	$ 6,560,584	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 240,664	$ 240,664	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,201	9,201	28
29	Short-Term Notes Payable	550,000	550,000	29
30	Accrued Salaries Payable	68,718	68,718	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,625	16,625	31
32	Accrued Real Estate Taxes(Sch.IX-B)	111,808	111,808	32
33	Accrued Interest Payable	995	995	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	799,615	964,759	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,797,626	$ 1,962,770	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,000,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,000,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,797,626	$ 5,962,770	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 673,118	$ 597,814	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,470,744	$ 6,560,584	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 341,794	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	106,085	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 447,879	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	426,499	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	(201,260)	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)**	$ 225,239	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)**	$ 673,118	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,603,990	1
2	Discounts and Allowances for all Levels	(629,044)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,974,946	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	685,718	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 685,718	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	55,221	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,162	19
20	Radiology and X-Ray	345	20
21	Other Medical Services	116	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 61,844	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,896	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,896	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	3,867	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,867	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,728,271	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	458,065	31
32	Health Care	1,094,197	32
33	General Administration	691,662	33
	B. Capital Expense		
34	Ownership	512,686	34
	C. Ancillary Expense		
35	Special Cost Centers	513,954	35
36	Provider Participation Fee	31,208	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,301,772	40
41	**Income before Income Taxes (line 30 minus line 40)****	426,499	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 426,499	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

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

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,029	2,326	$ 97,007	$ 41.71	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,268	5,739	170,492	29.71	3
4	Licensed Practical Nurses	9,113	9,970	242,626	24.34	4
5	CNAs & Orderlies	28,680	31,194	337,522	10.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,702	3,869	44,413	11.48	10
11	Social Service Workers	1,813	2,158	37,533	17.39	11
12	Dietician					12
13	Food Service Supervisor	1,945	2,062	36,364	17.64	13
14	Head Cook	4,228	4,415	45,682	10.35	14
15	Cook Helpers/Assistants	4,536	4,700	40,711	8.66	15
16	Dishwashers					16
17	Maintenance Workers	2,165	2,419	34,192	14.13	17
18	Housekeepers	5,398	5,707	51,125	8.96	18
19	Laundry	1,751	2,056	19,691	9.58	19
20	Administrator	1,901	2,086	80,591	38.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,916	2,085	23,419	11.23	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,330	3,729	74,730	20.04	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	77,775	84,515	$ 1,336,098 *	$ 15.81	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	197	$ 10,863	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	228	17,100	10-03	38
39	Pharmacist Consultant	56	2,789	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	38	1,924	11-03	44
45	Social Service Consultant	30	1,468	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	549	$ 46,144		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Heather Levine	Administrator	0.00%	$ 80,591
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 80,591

B. Administrative - Other

Description	Amount
Management Fees - Yosef Meystel	$ 15,000
YAM Consulting, LLC - Administrative Consulting	7,950
TOTAL (agree to Schedule V, line 17, col. 3)	$ 22,950
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Adar IT	Data Processing	$ 2,207
American Data	Data Processing	5,179
CAPSA Solutions	Data Processing	154
Health Data Systems Inc.	Data Processing	2,355
YAM Consulting, LLC	Data Processing	5,136
YAM Management	Data Processing	856
YAM Management	Bookkeeping	52,900
Frost, Ruttenberg, & Rothblatt	Accounting	12,925
YAM Management	Accounting	36,000
Adj. Page5A	Legal	5,206
Holland & Knight	Legal	3,927
See Supplemetal Schedule		1,966
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 128,811

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 52,423
Unemployment Compensation Insurance	8,482
FICA Taxes	102,211
Employee Health Insurance	70,705
Employee Meals	20,148
Illinois Municipal Retirement Fund (IMRF)*	
Dental	247
Pension Plan Contribution	12,596
Other Employee Benefits	4,018
TOTAL (agree to Schedule V, line 22, col.8)	$ 270,830

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	1,380
(Indicate # of checks performed 138)	
Patient Background Checks	
Dues & Subscriptions	4,231
License & Permits	8,374
Advertising & Promtion	734
Allocated from Yam Management	199
See Supplemental Schedule	45
Less: Public Relations Expense	( )
Non-allowable advertising	(734)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,229

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,384
Allocated from Yam Management	307
Allocated from Yam Consulting	117
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,808

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center # 0048454 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ILCLTC - $5,103**

(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. $ **2,383** 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? **X** YES ____ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **20,148** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

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

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

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

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