

Facility Name & ID Number Rockford Nursing & Rehab Ctr

0050435 Report Period Beginning: 04/01/09 Ending: 12/31/09

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>52</u>	Skilled (SNF)	<u>52</u>	<u>14,300</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>45</u>	Intermediate (ICF)	<u>45</u>	<u>12,375</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>97</u>	TOTALS	<u>97</u>	<u>26,675</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	<u>848</u>		<u>1,239</u>	<u>2,087</u>	8
9	SNF/PED					9
10	ICF	<u>11,264</u>	<u>288</u>	<u>3,169</u>	<u>14,721</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,112</u>	<u>288</u>	<u>4,408</u>	<u>16,808</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.01%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 4/1/2009

J. Was the facility purchased or leased after January 1, 1978?
YES Date 4/1/2009 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 52 and days of care provided 1,239

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Rockford Nursing & Rehab Ctr # 0050435 Report Period Beginning: 04/01/09 Ending: 12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	138,823	14,416	5,643	158,882		158,882	(2,186)	156,696		1
2	Food Purchase		89,544		89,544	(10,725)	78,819	(239)	78,580		2
3	Housekeeping	66,116	12,162		78,278		78,278		78,278		3
4	Laundry	38,268	6,293	3,767	48,328		48,328		48,328		4
5	Heat and Other Utilities			78,854	78,854		78,854	358	79,212		5
6	Maintenance	37,149	3,267	48,862	89,278		89,278	11,139	100,417		6
7	Other (specify):*							1,404	1,404		7
8	TOTAL General Services	280,356	125,682	137,126	543,164	(10,725)	532,439	10,476	542,915		8
	B. Health Care and Programs										
9	Medical Director			10,800	10,800		10,800		10,800		9
10	Nursing and Medical Records	830,293	68,743	26,495	925,531		925,531	231	925,762		10
10a	Therapy	25,616			25,616		25,616		25,616		10a
11	Activities	43,457	8,725		52,182		52,182		52,182		11
12	Social Services	32,654	575	1,980	35,209		35,209	3,066	38,275		12
13	CNA Training										13
14	Program Transportation			4,437	4,437		4,437	958	5,395		14
15	Other (specify):*							4,715	4,715		15
16	TOTAL Health Care and Programs	932,020	78,043	43,712	1,053,775		1,053,775	8,970	1,062,745		16
	C. General Administration										
17	Administrative	87,906		43,200	131,106		131,106	(7,427)	123,679		17
18	Directors Fees										18
19	Professional Services			120,252	120,252		120,252	(98,352)	21,900		19
20	Dues, Fees, Subscriptions & Promotions			4,234	4,234		4,234	1,110	5,344		20
21	Clerical & General Office Expenses	40,256	167	153,566	193,989		193,989	(92,782)	101,207		21
22	Employee Benefits & Payroll Taxes			192,026	192,026	10,725	202,751		202,751		22
23	Inservice Training & Education										23
24	Travel and Seminar			455	455		455	591	1,046		24
25	Other Admin. Staff Transportation							519	519		25
26	Insurance-Prop.Liab.Malpractice			42,046	42,046		42,046	316	42,362		26
27	Other (specify):*							8,728	8,728		27
28	TOTAL General Administration	128,162	167	555,779	684,108	10,725	694,833	(187,297)	507,536		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,340,538	203,892	736,617	2,281,047		2,281,047	(167,851)	2,113,196		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.

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					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			3,728	3,728		3,728	(78)	3,650		30
31	Amortization of Pre-Op. & Org.			3,690	3,690		3,690		3,690		31
32	Interest			20,190	20,190		20,190	26	20,216		32
33	Real Estate Taxes			42,849	42,849		42,849		42,849		33
34	Rent-Facility & Grounds			309,374	309,374		309,374	2,722	312,096		34
35	Rent-Equipment & Vehicles			1,200	1,200		1,200	3,586	4,786		35
36	Other (specify):*										36
37	TOTAL Ownership			381,031	381,031		381,031	6,256	387,287		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		53,889	113,447	167,336		167,336		167,336		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			40,013	40,013		40,013		40,013		42
43	Other (specify):*	26,023			26,023		26,023	(26,023)			43
44	TOTAL Special Cost Centers	26,023	53,889	153,460	233,372		233,372	(26,023)	207,349		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,366,561	257,781	1,271,108	2,895,450		2,895,450	(187,617)	2,707,833		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 Rockford Nursing & Rehab Ctr

0050435

Report Period Beginning:

04/01/09

Ending:

12/31/09

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(5,932)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(688)	30		9
10	Interest and Other Investment Income				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				18
19	Entertainment	(1,602)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,542)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(136,025)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (148,804)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(38,813)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (38,813)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (187,617)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Rockford Nursing & Rehab Ctr

ID# 0050435

Report Period Beginning: 04/01/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Bank Charges	\$ (8,838)	21	1
2	Marketing Expense	(6,745)	21	2
3	Theft & Damage Loss	(915)	21	3
4	Vending Commissions	(224)	02	4
5	Marketing Salary	(26,023)	43	5
6	Capitalized R&M	9,904	06	6
7	Non-Allowable Office Expense	(87,302)	21	7
8	Non-Allowable Legal	(14,732)	19	8
9	Non-Allowable Office Expense	(1,150)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(136,025)		49

Rockford Nursing & Rehab Ctr

ID# 0050435

Report Period Beginning: 04/01/09

Ending: 12/31/09

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

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

04/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				(2,186)								(2,186)	1
2	Food Purchase	(239)											(239)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			358									358	5
6	Maintenance	3,972		2,429	4,738								11,139	6
7	Other (specify):*			619	785								1,404	7
8	TOTAL General Services	3,733		3,406	3,337								10,476	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				231								231	10
10a	Therapy													10a
11	Activities													11
12	Social Services				3,066								3,066	12
13	CNA Training													13
14	Program Transportation				958								958	14
15	Other (specify):*				4,715								4,715	15
16	TOTAL Health Care and Programs				8,970								8,970	16
	C. General Administration													
17	Administrative			6,630	(14,057)								(7,427)	17
18	Directors Fees													18
19	Professional Services	(14,732)		(78,143)	(5,477)								(98,352)	19
20	Fees, Subscriptions & Promotions			129	981								1,110	20
21	Clerical & General Office Expenses	(111,094)		28,646	(10,334)								(92,782)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			253	338								591	24
25	Other Admin. Staff Transportation			436	83								519	25
26	Insurance-Prop.Liab.Malpractice			316									316	26
27	Other (specify):*			7,382	1,346								8,728	27
28	TOTAL General Administration	(125,826)		(34,351)	(27,120)								(187,297)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(122,093)		(30,945)	(14,812)								(167,851)	29

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

04/01/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	D. Ownership													
	Depreciation	(688)		582	28								(78)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest			26									26	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds			2,722									2,722	34
35	Rent-Equipment & Vehicles			566	3,020								3,586	35
36	Other (specify):*													36
37	TOTAL Ownership	(688)		3,897	3,048								6,256	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):*	(26,023)											(26,023)	43
44	TOTAL Special Cost Centers	(26,023)											(26,023)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(148,804)		(27,049)	(11,764)								(187,617)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
David Berkowitz	40%	See Attached		See Attached		
Joshua Weinstein	20%					
Yosef Meystel	40%					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	YAM MANAGEMENT, LLC	100.00%	\$ 358	\$	358	15
16	V	6 REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	2,429		2,429	16
17	V	7 EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	619		619	17
18	V	17 ADMIN. - RELATED		YAM MANAGEMENT, LLC	100.00%	3,092		3,092	18
19	V	17 ADMIN. - NON RELATED		YAM MANAGEMENT, LLC	100.00%	3,538		3,538	19
20	V	19 PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	2,018		2,018	20
21	V	20 FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	129		129	21
22	V	21 CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	28,646		28,646	22
23	V	24 SEMINARS		YAM MANAGEMENT, LLC	100.00%	253		253	23
24	V	25 AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	436		436	24
25	V	26 INSURANCE		YAM MANAGEMENT, LLC	100.00%	316		316	25
26	V	27 EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	7,382		7,382	26
27	V	30 DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	582		582	27
28	V	32 INTEREST		YAM MANAGEMENT, LLC	100.00%	26		26	28
29	V	34 RENT		YAM MANAGEMENT, LLC	100.00%	2,722		2,722	29
30	V	35 AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	439		439	30
31	V	35 EQUIPMENT RENTAL		YAM MANAGEMENT, LLC	100.00%	127		127	31
32	V								32
33	V	19 BOOKKEEPING FEES	53,107	YAM MANAGEMENT, LLC	100.00%			(53,107)	33
34	V	19 ACCOUNTING	23,000	YAM MANAGEMENT, LLC	100.00%			(23,000)	34
35	V	17 MANAGEMENT FEES		YAM MANAGEMENT, LLC	100.00%				35
36	V	19 DATA PROCESSING	4,054					(4,054)	36
37	V								37
38	V								38
39	Total		\$ 80,161			\$ 53,112	\$ *	(27,049)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 DIETARY	\$	YAM CONSULTING, LLC	100.00%	\$ 4,738	\$ 4,738
16	V	7 EMP. BEN. GEN. SERV.		YAM CONSULTING, LLC	100.00%	785	785
17	V	10 NURSING SALARY		YAM CONSULTING, LLC	100.00%	25,631	25,631
18	V	12 SOCIAL SERVICES SALARY		YAM CONSULTING, LLC	100.00%	3,066	3,066
19	V	14 PROGRAM TRANSPORTATION		YAM CONSULTING, LLC	100.00%	958	958
20	V	15 EMP. BEN. HEALTHCARE		YAM CONSULTING, LLC	100.00%	4,715	4,715
21	V	17 ADMIN. - NON RELEATED		YAM CONSULTING, LLC	100.00%	3,643	3,643
22	V	19 PROFESSIONAL FEES		YAM CONSULTING, LLC	100.00%	347	347
23	V	20 FEES, SUBSCRIPTIONS		YAM CONSULTING, LLC	100.00%	981	981
24	V	21 CLERICAL & GENERAL		YAM CONSULTING, LLC	100.00%	5,066	5,066
25	V	24 SEMINARS		YAM CONSULTING, LLC	100.00%	338	338
26	V	25 AUTO AND TRAVEL		YAM CONSULTING, LLC	100.00%	83	83
27	V	27 EMP. BEN.-GEN. ADMIN.		YAM CONSULTING, LLC	100.00%	1,346	1,346
28	V	30 DEPRECIATION		YAM CONSULTING, LLC	100.00%	28	28
29	V	35 AUTO RENTAL		YAM CONSULTING, LLC	100.00%	3,020	3,020
30	V						
31	V						
32	V	01 DIETARY CONSULTING	2,186				(2,186)
33	V	10 NURSING CONSULTING	25,400				(25,400)
34	V	17 ADMIN. CONSULTING	17,700				(17,700)
35	V	17 DIR. OF OPERATIONS CONSULT					
36	V	19 DATA PROCESSING FEES	5,824				(5,824)
37	V	21 MARKETING	15,400				(15,400)
38	V						
39	Total		\$ 66,510			\$ 54,746	\$ * (11,764)

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Rockford Nursing & Rehab Ctr # 0050435 Report Period Beginning: 04/01/09 Ending: 12/31/09

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Shareholder	Administrative	40.00%	See Attached	2.10	5.25%	Mgmt Fees	\$ 9,000	17-3	1
2	David Berkowitz	Shareholder	Administrative	40.00%	See Attached			Mgmt Fees	16,500	17-3	2
3	Jay Meystel	Relative	Administrative	0.00%	See Attached	1.00	2.50%	Alloc. Sal.	1,901	17-7	3
4	Joel Meystel	Relative	Administrative	0.00%	See Attached	1.00	5.00%	Alloc. Sal.	1,192	17-7	4
5	Joshua Weinstein	Shareholder	Administrative	20.00%	See Attached	2.10	5.25%	Alloc. Sal.	7,181	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 35,774		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rockford Nursing & Rehab Ctr

0050435

Report Period Beginning:

04/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rockford Nursing & Rehab Ctr

0050435

Report Period Beginning:

04/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

YAM MANAGEMENT, LLC

Street Address

3501 W. HOWARD STREET

City / State / Zip Code

SKOKIE, ILLINOIS 60076

Phone Number

(847) 673-6767

Fax Number

(847) 673-6768

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	AVAIL. BED DAYS	516,637	12	\$ 6,943	\$ 26,675	\$ 358	1	
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	516,637	12	47,049	41,077	26,675	2,429	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	516,637	12	11,995	26,675	619	3	
4	17	ADMIN. - RELATED	AVAIL. BED DAYS	516,637	12	59,890	59,890	26,675	3,092	4
5	17	ADMIN. - NON RELATED	AVAIL. BED DAYS	516,637	12	68,520	68,520	26,675	3,538	5
6	19	PROFESSIONAL FEES	AVAIL. BED DAYS	516,637	12	39,084	26,675	2,018	6	
7	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	516,637	12	2,504	26,675	129	7	
8	21	CLERICAL & GENERAL	AVAIL. BED DAYS	516,637	12	554,814	499,630	26,675	28,646	8
9	24	SEMINARS	AVAIL. BED DAYS	516,637	12	4,893	26,675	253	9	
10	25	AUTO AND TRAVEL	AVAIL. BED DAYS	516,637	12	8,444	26,675	436	10	
11	26	INSURANCE	AVAIL. BED DAYS	516,637	12	6,121	26,675	316	11	
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	516,637	12	142,965	26,675	7,382	12	
13	30	DEPRECIATION	AVAIL. BED DAYS	516,637	12	11,270	26,675	582	13	
14	32	INTEREST	AVAIL. BED DAYS	516,637	12	513	26,675	26	14	
15	34	RENT	AVAIL. BED DAYS	516,637	12	52,725	26,675	2,722	15	
16	35	AUTO RENTAL	AVAIL. BED DAYS	516,637	12	8,509	26,675	439	16	
17	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	516,637	12	2,458	26,675	127	17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,028,697	\$ 669,116	\$ 53,112	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rockford Nursing & Rehab Ctr

0050435

Report Period Beginning:

04/01/09

Ending: 12/31/09

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

Name of Related Organization

YAM CONSULTING, LLC

Street Address

3501 W. HOWARD STREET

City / State / Zip Code

SKOKIE, ILLINOIS 60076

Phone Number

(847) 673-6767

Fax Number

(847) 673-6768

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	DIETARY	AVAIL. BED DAYS	516,637	12	\$ 91,773	\$ 89,792	26,675	\$ 4,738	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	516,637	12	15,208		26,675	785	2
3	10	NURSING SALARY	AVAIL. BED DAYS	516,637	12	496,414	496,414	26,675	25,631	3
4	12	SOCIAL SERVICES SALARY	AVAIL. BED DAYS	516,637	12	59,382	59,382	26,675	3,066	4
5	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	516,637	12	18,550		26,675	958	5
6	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	516,637	12	91,325		26,675	4,715	6
7	17	ADMIN. - NON RELEATED	AVAIL. BED DAYS	516,637	12	70,560	70,560	26,675	3,643	7
8	19	PROFESSIONAL FEES	AVAIL. BED DAYS	516,637	12	6,724		26,675	347	8
9	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	516,637	12	19,007		26,675	981	9
10	21	CLERICAL & GENERAL	AVAIL. BED DAYS	516,637	12	98,110	79,705	26,675	5,066	10
11	24	SEMINARS	AVAIL. BED DAYS	516,637	12	6,543		26,675	338	11
12	25	AUTO AND TRAVEL	AVAIL. BED DAYS	516,637	12	1,616		26,675	83	12
13	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	516,637	12	26,075		26,675	1,346	13
14	30	DEPRECIATION	AVAIL. BED DAYS	516,637	12	539		26,675	28	14
15	35	AUTO RENTAL	AVAIL. BED DAYS	516,637	12	58,491		26,675	3,020	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,060,316	\$ 795,852		\$ 54,746	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rockford Nursing & Rehab Ctr

0050435

Report Period Beginning:

04/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rockford Nursing & Rehab Ctr

0050435

Report Period Beginning:

04/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rockford Nursing & Rehab Ctr

0050435

Report Period Beginning:

04/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rockford Nursing & Rehab Ctr

0050435

Report Period Beginning:

04/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rockford Nursing & Rehab Ctr

0050435

Report Period Beginning:

04/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rockford Nursing & Rehab Ctr

0050435 Report Period Beginning: 04/01/09 Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rockford Nursing & Rehab Ctr

0050435

Report Period Beginning:

04/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Rockford Nursing & Rehab Ctr

0050435

Report Period Beginning:

04/01/09

Ending:

12/31/09

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

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

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

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and			
1. Real Estate Tax accrual used on 2008 report.		\$	54,411		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.)		\$	54,411		2
3. Under or (over) accrual (line 2 minus line 1).		\$			3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	42,849		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	42,849		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2004	_____	8	FOR BHF USE ONLY	
	2005	_____	9	13	FROM R. E. TAX STATEMENT FOR 2008 \$ 13
	2006	_____	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2007	_____	11	15	LESS REFUND FROM LINE 6 \$ 15
	2008	54,411	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
There was no real estate accrual at the beginning of the year because of the change in ownership.					
Beginning Accrual Adjusted					

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rockford Nursing & Rehab Ctr

0050435 Report Period Beginning:

04/01/09 Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

None

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

1. Total Amount Incurred: 4,920 2. Number of Years Over Which it is Being Amortized: 1 (12 Months)
 3. Current Period Amortization: 3,690 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rockford Nursing & Rehab Ctr

0050435

Report Period Beginning:

04/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

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

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68			1,517	16	100	84	198	68
69				2,754		(2,754)		69
70		\$	\$		\$	\$	\$	70
TOTAL (lines 4 thru 69)		1,517	2,770		100	(2,670)	198	

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,517	\$ 2,770		\$ 100	\$ (2,670)	\$ 198	1
2	Air Conditioner/Water Heater	2009	4,468		20	223	223	223	2
3	Hd Receivers/Dish/Camera System/Wiring	2009	3,825		20	191	191	191	3
4	Water Heater	2009	6,350		20	318	318	318	4
5	Hot Water System /Boiler	2009	5,524		20	276	276	276	5
6	Camera/Cable	2009	9,174		20	459	459	459	6
7	Front Door Entrance Alarm	2009	2,710		20	136	136	136	7
8	Headend Hardware & Installation	2009	6,200		20	310	310	310	8
9	Drop Ceiling/Lighting	2009	5,060		20	253	253	253	9
10	Wiring For Camera/Dish	2009	2,650		20	133	133	133	10
11	Camera/Cable	2009	3,319		20	166	166	166	11
12	Smoke Detectors /Sprinker Heads	2009	3,060		20	153	153	153	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)		\$ 53,857	\$ 2,770		\$ 2,717	\$ (53)	\$ 2,815	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 53,857	\$ 2,770		\$ 2,717	\$ (53)	\$ 2,815	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)	\$ 53,857	\$ 2,770		\$ 2,717	\$ (53)	\$ 2,815	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 53,857	\$ 2,770		\$ 2,717	\$ (53)	\$ 2,815	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)	\$ 53,857	\$ 2,770		\$ 2,717	\$ (53)	\$ 2,815	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rockford Nursing & Rehab Ctr

0050435

Report Period Beginning:

04/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 53,857	\$ 2,770		\$ 2,717	\$ (53)	\$ 2,815	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)	\$ 53,857	\$ 2,770		\$ 2,717	\$ (53)	\$ 2,815	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	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.

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1 Related Party Information		\$	\$		\$	\$	\$
2 Buildings:							
3							
4							
5							
6							
7							
8 Leasehold Improvements:							
9 Allocated From YAM Management	2007	1,105	7	20	64	57	158
10 Allocated From YAM Management	2008	76	2	20	8	6	12
11 Allocated From YAM Management	2009	336	7	20	28	21	28
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34							

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)	\$ 1,517	\$ 16		\$ 100	\$ 84	\$ 198	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

0050435

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XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,493	\$ 63	\$ 171	\$ 108	10	\$ 394	71
72	Current Year Purchases	4,577	1,270	451	(819)	10	451	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 6,070	\$ 1,333	\$ 622	\$ (711)		\$ 845	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated From YAM Manageme	2009	\$ 1,220	\$ 235	\$ 311	\$ 76	5	\$ 494	76
77										77
78										78
79										79
80	TOTALS			\$ 1,220	\$ 235	\$ 311	\$ 76		\$ 494	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)	\$ 61,147	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 4,338	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 3,650	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (688)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,154	85

**

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

If NO, see instructions. YES NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>97</u>		\$ <u>309,374</u>			3
4	Additions						4
5	<u>Allocated From YAM Management</u>			<u>2,722</u>			5
6							6
7	TOTAL	<u>97</u>		\$ <u>312,096</u>			7

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 4,347 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocated From YAM Management</u>		\$ _____	\$ <u>439</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>439</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	39 - 03	hrs					\$ 48,404							\$ 48,404	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					2,231							2,231	2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39 - 03	hrs					60,425							60,425	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							52,146					52,146	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							2,387		1,743					4,130	13
14	TOTAL				\$			\$ 113,447		\$ 53,889				\$	167,336	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Rockford Nursing & Rehab Ctr**# **0050435**Report Period Beginning: **04/01/09**

Ending:

12/31/09**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/09**

(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	\$ 35,050	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	834,652		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,901		6
7	Other Prepaid Expenses	623		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	95,028		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 993,254	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	38,357		15
16	Equipment, at Historical Cost	28,168		16
17	Accumulated Depreciation (book methods)	(3,728)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	1,230		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 64,027	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,057,281	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 641,720	\$	26
27	Officer's Accounts Payable	11,000		27
28	Accounts Payable-Patient Deposits	1,237		28
29	Short-Term Notes Payable	350,000		29
30	Accrued Salaries Payable	153,850		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,918		31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,849		32
33	Accrued Interest Payable	389		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	172,088		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,379,051	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,379,051	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (321,770)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,057,281	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

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

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Rockford Nursing & Rehab Ctr**# **0050435**Report Period Beginning: **04/01/09**Ending: **12/31/09**

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,142,056	1
2	Discounts and Allowances for all Levels	2,555	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,144,611	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	256,887	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 256,887	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	49,572	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,065	19
20	Radiology and X-Ray	189	20
21	Other Medical Services	1,632	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 59,458	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	224	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 224	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,461,180	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	543,164	31
32	Health Care	1,053,775	32
33	General Administration	684,108	33
B. Capital Expense			
34	Ownership	381,031	34
C. Ancillary Expense			
35	Special Cost Centers	193,359	35
36	Provider Participation Fee	40,013	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,895,450	40
41	Income before Income Taxes (line 30 minus line 40)**	(434,270)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (434,270)	43

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

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

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

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

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

0050435

Report Period Beginning:

04/01/09

Ending:

12/31/09

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,535	1,610	\$ 46,478	\$ 28.87	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,635	3,756	109,293	29.10	3
4	Licensed Practical Nurses	10,547	10,912	267,877	24.55	4
5	CNAs & Orderlies	30,863	32,224	343,870	10.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,305	2,401	25,616	10.67	8
9	Activity Director	1,560	1,624	15,773	9.71	9
10	Activity Assistants	2,882	2,969	27,684	9.32	10
11	Social Service Workers	1,614	1,658	32,654	19.69	11
12	Dietician					12
13	Food Service Supervisor	1,535	1,578	22,646	14.35	13
14	Head Cook	4,009	4,300	51,133	11.89	14
15	Cook Helpers/Assistants	6,476	6,817	65,044	9.54	15
16	Dishwashers					16
17	Maintenance Workers	2,774	2,900	37,149	12.81	17
18	Housekeepers	6,036	6,343	66,116	10.42	18
19	Laundry	3,685	3,880	38,268	9.86	19
20	Administrator	1,599	1,674	87,906	52.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,736	3,888	40,256	10.35	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	3,884	3,118	62,775	20.13	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,039	1,074	26,023	24.23	33
34	TOTAL (lines 1 - 33)	89,714	92,726	\$ 1,366,561 *	\$ 14.74	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	112	\$ 5,643	01-03	35
36	Medical Director	Monthly	10,800	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	368	26,014	10-03	38
39	Pharmacist Consultant	Monthly	481	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	36	1,980	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	516	\$ 44,918		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Gregory Taylor	Administrator	0.00%	\$ 87,906	Workers' Compensation Insurance	\$ 41,700	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	22,401	Advertising: Employee Recruitment	1,200	
				FICA Taxes	96,973	Health Care Worker Background Check	1,240	
				Employee Health Insurance	29,157	(Indicate # of checks performed <u>124</u>)		
				Employee Meals	10,725	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	449	
				Employee Physicals	112	Licenses & Permits	350	
				Other Employee Benefits	1,683	Allocated From YAM Management	129	
						Allocated From YAM Consulting	981	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 87,906	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
						Less: Public Relations Expense ()		
						Non-allowable advertising ()		
						Yellow page advertising ()		
B. Administrative - Other								
Description			Amount					
Yam Consulting - Administrative Consulting			\$ 17,700					
Yosef Meystel- Management Fees			9,000					
David Berkowitz- Management Fees			16,500					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 43,200					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount	
YAM Consulting	Data Processing	\$ 5,824				Out-of-State Travel	\$	
YAM Management	Bookkeeping	53,107						
Frost, Ruttenberg & Rothblatt	Accounting	1,610						
YAM Management	Accounting	23,000				In-State Travel		
See Attached	Legal	18,139						
Personnel Planners	Unemployment Consulting	419						
HDSI	Data Processing	6,327						
E-Health Data Solutions	Data Processing	4,218				Seminar Expense	455	
American Data	Data Processing	3,554				Allocated From YAM Management	253	
YAM Management	Data Processing	4,054				Allocated From YAM Consulting	338	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 120,252	TOTAL		Entertainment Expense () (agree to Sch. V, line 24, col. 8)		
						TOTAL		
						\$ 1,046		

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009
1	N/A			\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS			\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rockford Nursing & Rehab Ctr# 0050435Report Period Beginning: 04/01/09Ending: 12/31/09**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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. \$ 7,009 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 40,013
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 10,725 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? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.