

Facility Name & ID Number Plaza Nursing and Rehab Center

0049858 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	48	Skilled (SNF)	48	17,520	1
2		Skilled Pediatric (SNF/PED)			2
3	43	Intermediate (ICF)	43	15,695	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	91	TOTALS	91	33,215	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	4 Private Pay	Other	Total	
8	SNF	2,482	25	1,935	4,442	8
9	SNF/PED					9
10	ICF	22,328	219	3,391	25,938	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,810	244	5,326	30,380	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.46%

D. How many bed-hold days during this year were paid by the Department? 187 (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 01/01/08

J. Was the facility purchased or leased after January 1, 1978?
YES Date 01/01/08 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 48 and days of care provided 1,935

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: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number Plaza Nursing and Rehab Center # 0049858 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	170,863	13,912	15,428	200,203		200,203	(7,816)	192,387		1
2	Food Purchase		133,412		133,412	(14,345)	119,068	(11)	119,057		2
3	Housekeeping	140,505	15,723		156,228		156,228		156,228		3
4	Laundry	28,397	8,049		36,446		36,446		36,446		4
5	Heat and Other Utilities			70,452	70,452		70,452	961	71,413		5
6	Maintenance	34,419	11,288	72,830	118,537		118,537	3,539	122,076		6
7	Other (specify):*							1,254	1,254		7
8	TOTAL General Services	374,184	182,384	158,710	715,278	(14,345)	700,934	(2,073)	698,861		8
	B. Health Care and Programs										
9	Medical Director			15,250	15,250		15,250		15,250		9
10	Nursing and Medical Records	1,074,379	43,413	101,004	1,218,796		1,218,796	(67,053)	1,151,743		10
10a	Therapy										10a
11	Activities	57,880	7,052	3,452	68,384		68,384		68,384		11
12	Social Services	64,828		2,060	66,888		66,888	166	67,054		12
13	CNA Training										13
14	Program Transportation			460	460		460	1,846	2,306		14
15	Other (specify):*							3,590	3,590		15
16	TOTAL Health Care and Programs	1,197,087	50,465	122,226	1,369,778		1,369,778	(61,451)	1,308,327		16
	C. General Administration										
17	Administrative	84,281		58,000	142,281		142,281	(11,500)	130,781		17
18	Directors Fees										18
19	Professional Services			162,525	162,525		162,525	(116,762)	45,763		19
20	Dues, Fees, Subscriptions & Promotions			21,353	21,353		21,353	(12,324)	9,029		20
21	Clerical & General Office Expenses	85,616	70	103,944	189,630		189,630	(20,481)	169,149		21
22	Employee Benefits & Payroll Taxes			294,224	294,224	14,345	308,569		308,569		22
23	Inservice Training & Education										23
24	Travel and Seminar			520	520		520	848	1,368		24
25	Other Admin. Staff Transportation			885	885		885	1,366	2,251		25
26	Insurance-Prop.Liab.Malpractice			83,535	83,535		83,535	1,127	84,662		26
27	Other (specify):*							12,580	12,580		27
28	TOTAL General Administration	169,897	70	724,986	894,953	14,345	909,298	(145,145)	764,152		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,741,168	232,919	1,005,922	2,980,009		2,980,009	(208,669)	2,771,340		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 Plaza Nursing and Rehab Center

#0049858

Report Period Beginning:

01/01/10

Ending:

12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			140,189	140,189		140,189	(119,609)	20,580			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			37,922	37,922		37,922	3,593	41,515			32
33	Real Estate Taxes			148,148	148,148		148,148	1,799	149,947			33
34	Rent-Facility & Grounds			417,892	417,892		417,892	1,531	419,423			34
35	Rent-Equipment & Vehicles			2,338	2,338		2,338	4,222	6,560			35
36	Other (specify):*			2,917	2,917		2,917		2,917			36
37	TOTAL Ownership			749,406	749,406		749,406	(108,464)	640,942			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		78,315	159,087	237,402		237,402		237,402			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,823	49,823		49,823		49,823			42
43	Other (specify):*	54,368		191,083	245,451		245,451	(245,451)	0			43
44	TOTAL Special Cost Centers	54,368	78,315	399,993	532,676		532,676	(245,451)	287,225			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,795,536	311,234	2,155,321	4,262,091		4,262,091	(562,585)	3,699,506			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,224)	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	(123,167)	30		9
10	Interest and Other Investment Income	(140)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(11)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(4,721)	21		19
20	Contributions	(4,150)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(65,708)	21		24
25	Fund Raising, Advertising and Promotional	(5,138)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(231,277)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (438,537)		\$	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)	(124,048)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (124,048)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (562,585)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Plaza Nursing and Rehab Center

ID# 0049858

Report Period Beginning: 01/01/10

Ending: 12/31/10

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Marketing Salary	\$ (54,368)	43	1
2	Theft Loss	(441)	21	2
3	COPE Dues	(3,396)	20	3
4	Bank Charges	(4,150)	21	4
5	Capitalized R&M	(13,450)	06	5
6	Additional R&M & Combined Asset	18,803	06	6
7	Other Unclassified Income	(177)	21	7
8	Non-Allowable Fees	(165,391)	43	8
9	Loan Costs	(5,000)	21	9
10	Legal Expense	(3,707)	19	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	(231,277)		49

Plaza Nursing and Rehab Center

ID# 0049858

Report Period Beginning: 01/01/10

Ending: 12/31/10

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Plaza Nursing and Rehab Center# 0049858

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

	Operating Expenses	PAGES 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				(7,816)								(7,816)	1
2	Food Purchase	(11)											(11)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			961									961	5
6	Maintenance	1,129		2,368		42							3,539	6
7	Other (specify):*			371	883								1,254	7
8	TOTAL General Services	1,118		3,700	(6,933)	42							(2,073)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				(67,053)								(67,053)	10
10a	Therapy													10a
11	Activities													11
12	Social Services				166								166	12
13	CNA Training													13
14	Program Transportation				1,846								1,846	14
15	Other (specify):*				3,590								3,590	15
16	TOTAL Health Care and Programs				(61,451)								(61,451)	16
	C. General Administration													
17	Administrative			6,661	(18,161)								(11,500)	17
18	Directors Fees													18
19	Professional Services	(3,707)		(106,540)	(8,050)	1,535							(116,762)	19
20	Fees, Subscriptions & Promotions	(12,684)		236	43	81							(12,324)	20
21	Clerical & General Office Expenses	(80,198)		53,447	6,234	36							(20,481)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			285	563								848	24
25	Other Admin. Staff Transportation			1,196	170								1,366	25
26	Insurance-Prop.Liab.Malpractice			1,127									1,127	26
27	Other (specify):*			10,916	1,664								12,580	27
28	TOTAL General Administration	(96,588)		(32,672)	(17,537)	1,652							(145,145)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(95,470)		(28,972)	(85,921)	1,694							(208,669)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Plaza Nursing and Rehab Center# 0049858

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	D. Ownership													
	Depreciation	(123,167)		2,760	31	767							(119,609)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(140)		19		3,714							3,593	32
33	Real Estate Taxes			1,708		90							1,799	33
34	Rent-Facility & Grounds			9,964		(8,433)							1,531	34
35	Rent-Equipment & Vehicles			1,030	3,192								4,222	35
36	Other (specify):*													36
37	TOTAL Ownership	(123,307)		15,481	3,223	(3,861)							(108,464)	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):*	(219,759)			(25,692)								(245,451)	43
44	TOTAL Special Cost Centers	(219,759)			(25,692)								(245,451)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(438,537)		(13,490)	(108,391)	(2,167)							(562,585)	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
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES 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%	\$ 961	\$	961	15
16	V	6 REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	2,368		2,368	16
17	V	7 EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	371		371	17
18	V	17 ADMIN. - RELATED		YAM MANAGEMENT, LLC	100.00%	4,721		4,721	18
19	V	17 ADMIN. - NON RELATED		YAM MANAGEMENT, LLC	100.00%	1,940		1,940	19
20	V	19 PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	4,279		4,279	20
21	V	20 FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	236		236	21
22	V	21 CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	53,447		53,447	22
23	V	24 SEMINARS		YAM MANAGEMENT, LLC	100.00%	285		285	23
24	V	25 AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	1,196		1,196	24
25	V	26 INSURANCE		YAM MANAGEMENT, LLC	100.00%	1,127		1,127	25
26	V	27 EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	10,916		10,916	26
27	V	30 DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	2,760		2,760	27
28	V	32 INTEREST		YAM MANAGEMENT, LLC	100.00%	19		19	28
29	V	33 REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%	1,708		1,708	29
30	V	34 RENT		YAM MANAGEMENT, LLC	100.00%	9,964		9,964	30
31	V	35 AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	593		593	31
32	V	35 EQUIPMENT RENTAL		YAM MANAGEMENT, LLC	100.00%	437		437	32
33	V								33
34	V								34
35	V	19 BOOKKEEPING FEES	74,819	YAM MANAGEMENT, LLC	100.00%			(74,819)	35
36	V	19 ACCOUNTING	36,000	YAM MANAGEMENT, LLC	100.00%			(36,000)	36
37	V								37
38	V								38
39	Total		\$ 110,819			\$ 97,329	\$ *	(13,490)	39

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

Facility Name & ID Number Plaza Nursing and Rehab Center

0049858

Report Period Beginning: 01/01/10

Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	<u>1</u> DIETARY	\$	<u>YAM CONSULTING, LLC</u>	100.00%	\$ 7,612	\$ 7,612
16	V	<u>7</u> EMP. BEN. GEN. SERV.		<u>YAM CONSULTING, LLC</u>	100.00%	883	883
17	V	<u>10</u> NURSING SALARY		<u>YAM CONSULTING, LLC</u>	100.00%	28,618	28,618
18	V	<u>12</u> SOCIAL SERVICES SALARY		<u>YAM CONSULTING, LLC</u>	100.00%	166	166
19	V	<u>14</u> PROGRAM TRANSPORTATION		<u>YAM CONSULTING, LLC</u>	100.00%	1,846	1,846
20	V	<u>15</u> EMP. BEN. HEALTHCARE		<u>YAM CONSULTING, LLC</u>	100.00%	3,590	3,590
21	V	<u>17</u> ADMIN. - NON RELEATED		<u>YAM CONSULTING, LLC</u>	100.00%	5,839	5,839
22	V	<u>19</u> PROFESSIONAL FEES		<u>YAM CONSULTING, LLC</u>	100.00%	146	146
23	V	<u>20</u> FEES, SUBSCRIPTIONS		<u>YAM CONSULTING, LLC</u>	100.00%	43	43
24	V	<u>21</u> CLERICAL & GENERAL		<u>YAM CONSULTING, LLC</u>	100.00%	6,234	6,234
25	V	<u>24</u> SEMINARS		<u>YAM CONSULTING, LLC</u>	100.00%	563	563
26	V	<u>25</u> AUTO AND TRAVEL		<u>YAM CONSULTING, LLC</u>	100.00%	170	170
27	V	<u>27</u> EMP. BEN.-GEN. ADMIN.		<u>YAM CONSULTING, LLC</u>	100.00%	1,664	1,664
28	V	<u>30</u> DEPRECIATION		<u>YAM CONSULTING, LLC</u>	100.00%	31	31
29	V	<u>35</u> AUTO RENTAL		<u>YAM CONSULTING, LLC</u>	100.00%	3,192	3,192
30	V						
31	V						
32	V						
33	V	<u>01</u> DIETARY CONSULTING	15,428				(15,428)
34	V	<u>10</u> NURSE CONSULTING	95,671				(95,671)
35	V	<u>17</u> DIR. OF OPERATIONS CONSULT	24,000				(24,000)
36	V	<u>19</u> DATA PROCESSING FEES	8,196				(8,196)
37	V	<u>43</u> MARKETING	25,692				(25,692)
38	V						
39	Total		\$ 168,987			\$ 60,596	\$ * (108,391)

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 REPAIRS & MAINTENANCE	\$	8131 N. MONTICELLO, LLC	100.00%	\$ 42	\$	42	15
16	V	19 PROFESSIONAL FEES		8131 N. MONTICELLO, LLC		1,535		1,535	16
17	V	20 DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		81		81	17
18	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC		36		36	18
19	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC		767		767	19
20	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC		3,714		3,714	20
21	V	33 REAL ESTATE TAXES	1,708	8131 N. MONTICELLO, LLC		1,798		90	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34 RENT	8,433	8131 N. MONTICELLO, LLC				(8,433)	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		\$ 10,141			\$ 7,974	\$ *	(2,167)	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.

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:	
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:	
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 Plaza Nursing and Rehab Center # 0049858 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Owner	Administrative	46.50%	See Attached	2.3	5.75%	Mgmt. Fees	\$ 13,000	17-03	1
2	Joshua Weinstein	Owner	Administrative	3.00%	See Attached	2.3	5.75%	Alloc. Salary	7,779	17-07	2
3	David Berkowitz	Owner	Administrative	39.50%	See Attached	2.3	5.75%	Mgmt. Fees	21,000	17-03	3
4	Jay Meystel	Relative	Administrative	0%	See Attached	1.1	2.75%	Alloc. Salary	3,265	17-07	4
5	Joel Meystel	Relative	Administrative	0%	See Attached	1.1	5.50%	Alloc. Salary	1,456	17-07	5
6	Shimon Meystel	Relative	Clerical	0%	See Attached	2.3	5.75%	Alloc. Salary	773	21-07	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 47,273		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 Plaza Nursing and Rehab Center

0049858

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plaza Nursing and Rehab Center

0049858

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization YAM MANAGEMENT, LLC
 Street Address 8131 N. MONTICELLO
 City / State / Zip Code SKOKIE, ILLINOIS 60076
 Phone Number (847) 673-6767
 Fax Number (847) 673-6768

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	AVAIL. BED DAYS	579,474	16	\$ 16,764	\$ 33,215	\$ 961	1	
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	579,474	16	41,306	29,925	33,215	2,368	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	579,474	16	6,478	33,215	371	3	
4	17	ADMIN. - RELATED	AVAIL. BED DAYS	579,474	16	82,362	82,362	33,215	4,721	4
5	17	ADMIN. - NON RELATED	AVAIL. BED DAYS	579,474	16	33,843	33,843	33,215	1,940	5
6	19	PROFESSIONAL FEES	AVAIL. BED DAYS	579,474	16	74,656	33,215	4,279	6	
7	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	579,474	16	4,114	33,215	236	7	
8	21	CLERICAL & GENERAL	AVAIL. BED DAYS	579,474	16	932,452	841,703	33,215	53,447	8
9	24	SEMINARS	AVAIL. BED DAYS	579,474	16	4,974	33,215	285	9	
10	25	AUTO AND TRAVEL	AVAIL. BED DAYS	579,474	16	20,872	33,215	1,196	10	
11	26	INSURANCE	AVAIL. BED DAYS	579,474	16	19,661	33,215	1,127	11	
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	579,474	16	190,434	33,215	10,916	12	
13	30	DEPRECIATION	AVAIL. BED DAYS	579,474	16	48,156	33,215	2,760	13	
14	32	INTEREST	AVAIL. BED DAYS	579,474	16	331	33,215	19	14	
15	33	REAL ESTATE TAX	AVAIL. BED DAYS	579,474	16	29,806	33,215	1,708	15	
16	34	RENT	AVAIL. BED DAYS	579,474	16	173,825	33,215	9,964	16	
17	35	AUTO RENTAL	AVAIL. BED DAYS	579,474	16	10,347	33,215	593	17	
18	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	579,474	16	7,632	33,215	437	18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,698,015	\$ 987,832	\$ 97,329	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plaza Nursing and Rehab Center

0049858

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization YAM CONSULTING, LLC
 Street Address 8131 N. MONTICELLO
 City / State / Zip Code SKOKIE, ILLINOIS 60076
 Phone Number (847) 673-6767
 Fax Number (847) 673-6768

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY	AVAIL. BED DAYS	579,474	16	\$ 132,801	\$ 123,648	33,215	\$ 7,612	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	579,474	16	15,402		33,215	883	2
3	10	NURSING SALARY	AVAIL. BED DAYS	579,474	16	499,281	499,281	33,215	28,618	3
4	12	SOCIAL SERVICES SALARY	AVAIL. BED DAYS	579,474	16	2,888	2,888	33,215	166	4
5	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	579,474	16	32,206		33,215	1,846	5
6	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	579,474	16	62,625		33,215	3,590	6
7	17	ADMIN. - NON RELEATED	AVAIL. BED DAYS	579,474	16	101,866	101,866	33,215	5,839	7
8	19	PROFESSIONAL FEES	AVAIL. BED DAYS	579,474	16	2,550		33,215	146	8
9	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	579,474	16	755		33,215	43	9
10	21	CLERICAL & GENERAL	AVAIL. BED DAYS	579,474	16	108,757	86,009	33,215	6,234	10
11	24	SEMINARS	AVAIL. BED DAYS	579,474	16	9,816		33,215	563	11
12	25	AUTO AND TRAVEL	AVAIL. BED DAYS	579,474	16	2,967		33,215	170	12
13	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	579,474	16	29,022		33,215	1,664	13
14	30	DEPRECIATION	AVAIL. BED DAYS	579,474	16	539		33,215	31	14
15	35	AUTO RENTAL	AVAIL. BED DAYS	579,474	16	55,686		33,215	3,192	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,057,162	\$ 813,692		\$ 60,596	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plaza Nursing and Rehab Center

0049858

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

8131 N. MONTICELLO LLC

Street Address

8131 N. MONTICELLO

City / State / Zip Code

SKOKIE, ILLINOIS 60076

Phone Number

(847) 673-6767

Fax Number

(847) 673-6768

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	REPAIRS & MAINTENANCE	PATIENT DAYS	579,474	16	\$ 732	\$ 33,215	\$ 42	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	579,474	16	26,780	33,215	1,535	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	579,474	16	1,405	33,215	81	3
4	21	OFFICE EXPENSE	PATIENT DAYS	579,474	16	630	33,215	36	4
5	30	DEPRECIATION	PATIENT DAYS	579,474	16	13,389	33,215	767	5
6	32	INTEREST EXPENSE	PATIENT DAYS	579,474	16	64,796	33,215	3,714	6
7	33	REAL ESTATE TAXES	PATIENT DAYS	579,474	16	31,375	33,215	1,798	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 139,107	\$	\$ 7,974	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plaza Nursing and Rehab Center

0049858

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plaza Nursing and Rehab Center

0049858

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plaza Nursing and Rehab Center

0049858

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plaza Nursing and Rehab Center

0049858

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Plaza Nursing and Rehab Center**

0049858 Report Period Beginning: **01/01/10** Ending: **12/31/10**

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plaza Nursing and Rehab Center

0049858

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Plaza Nursing and Rehab Center

0049858

Report Period Beginning:

01/01/10

Ending:

12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1										1									
2										2									
3										3									
4										4									
5	See Supplemental Schedule																		
Working Capital																			
6	First Bank		X	Line of Credit			271,796			37,922	6								
7	Yam Management Alloc.	X								19	7								
8	See Supplemental Schedule																		
9	TOTAL Facility Related					\$	\$ 271,796			\$ 41,655	9								
B. Non-Facility Related*																			
10	Interest Income																		
11										(140)	10								
12											11								
13	See Supplemental Schedule																		
14	TOTAL Non-Facility Related					\$	\$			\$ (140)	14								
15	TOTALS (line 9+line14)					\$	\$ 271,796			\$ 41,515	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

Plaza Nursing and Rehab Center

0049858

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

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

1	2	3	4	5	6		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	8131 N. Monticello Alloc.	X				\$	\$			\$	3,714	8						
9												9						
10												10						
11												11						
12												12						
13												13						
14	TOTAL Working Capital										3,714	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Plaza Nursing and Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049858

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original second installment tax bill.

Facility Name & ID Number Plaza Nursing and Rehab Center

0049858

Report Period Beginning:

01/01/10

Ending:

12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,780 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

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).

N/A

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: _____ 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plaza Nursing and Rehab Center

0049858

Report Period Beginning:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)

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

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

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

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

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

Facility Name & ID Number Plaza Nursing and Rehab Center

0049858

Report Period Beginning:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)

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

1	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		72,400	787		1,151	364	1,262	68
69			122,262			(122,262)		69
70		\$ 72,400	\$ 123,049		\$ 1,151	\$ (121,898)	\$ 1,262	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Plaza Nursing and Rehab Center

0049858

Report Period Beginning:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 72,400	\$ 123,049		\$ 1,151	\$ (121,898)	\$ 1,262	1
2	Plumbing, Tiles, Wall Work, Electrical Work	2008	16,350		20	1,635	1,635	4,224	2
3	Plumbing, Tiles, Wall Work, Toilet, Sink, Door, Lights	2008	15,310		20	1,531	1,531	3,700	3
4	Judicial Rec. Sink & Fixtures	2008	15,310		20	1,021	1,021	2,467	4
5	V&M Concrete Contractors (Moonies Landscaping)	2008	3,588		20	359	359	807	5
6	Cable System	2009	9,650		20	1,930	1,930	3,056	6
7	Roofing	2009	4,930		20	493	493	698	7
8	S. Electronic Service - Door Alarms	2009	4,036		20	202	202	370	8
9	Ceramic / Vct Flooring	2009	16,740		20	837	837	977	9
10	Flooring	2009	4,600		20	230	230	364	10
11	Wiring Of Communication System	2009	3,898		20	195	195	325	11
12	Corridor Handrails/Bumper Guards	2010	26,339		20	877	877	877	12
13	John Deere Generator	2010	39,278		20	1,308	1,308	1,308	13
14	Panel Remote Annunciator	2010	6,603		20	220	220	220	14
15	Code Violations - Architect	2010	5,764		20	153	153	153	15
16	Panic Devices And Handles	2010	2,929		20	98	98	98	16
17	Connection To Generator	2010	9,750		20	325	325	325	17
18	Install Door/ Carpentry	2010	6,056		20	202	202	202	18
19	Acoustical Ceiling Suspension	2010	4,910		20	164	164	164	19
20	36" Fire Rated Door	2010	2,950		20	98	98	98	20
21	36" Fire Rated Door	2010	3,450		20	115	115	115	21
22	Tuck Pointing, Chimney Repairs, Rebuild Retaining Wall	2010	10,950		20	548	548	548	22
23	Repairs To Hydro-Jet And Pump Basins	2010	2,500		20	125	125	125	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)		\$ 288,291	\$ 123,049		\$ 13,814	\$ (109,235)	\$ 22,481	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		\$ 288,291	\$ 123,049		\$ 13,814	\$ (109,235)	\$ 22,481
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$ 288,291	\$ 123,049		\$ 13,814	\$ (109,235)	\$ 22,481

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		\$ 288,291	\$ 123,049		\$ 13,814	\$ (109,235)	\$ 22,481	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)	\$ 288,291	\$ 123,049		\$ 13,814	\$ (109,235)	\$ 22,481	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Plaza Nursing and Rehab Center

0049858

Report Period Beginning:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 288,291	\$ 123,049		\$ 13,814	\$ (109,235)	\$ 22,481	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)	\$ 288,291	\$ 123,049		\$ 13,814	\$ (109,235)	\$ 22,481	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated 8131 N. Monticello	2010	51,073	541		540	(1)	540	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated 8131 N. Monticello	2010	17,756	226	20	478	252	478	9
10	Allocated YAM Management	2007	1,227	4	20	61	57	192	10
11	Allocated YAM Management	2008	84	1	20	4	3		11
12	Allocated YAM Management	2009	372	4	20	16	12		12
13	Allocated YAM Management	2010	1,888	11	20	52	41	52	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 (12H & 12I lines 1 thru 33)		\$ 72,400	\$ 787		\$ 1,151	\$ 364	\$ 1,262	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Plaza Nursing and Rehab Center

0049858

Report Period Beginning:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 31,767	\$ 6,120	\$ 5,546	\$ (574)	10	\$ 10,353	71
72	Current Year Purchases	4,339	14,422	976	(13,446)	10	976	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 36,106	\$ 20,542	\$ 6,522	\$ (14,020)		\$ 11,329	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated YAM Management	2009	\$ 1,354	\$ 155	\$ 242	\$ 87	5	\$ 790	76
77										77
78										78
79										79
80	TOTALS			\$ 1,354	\$ 155	\$ 242	\$ 87		\$ 790	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)	\$ 325,751	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 143,746	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 20,579	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (123,167)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 34,600	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Plaza Nursing Realty, 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>91</u>		\$ <u>417,892</u>			3
4	Additions						4
5	<u>Allocated from YAM Management</u>			<u>1,531</u>			5
6							6
7	TOTAL	<u>91</u>		\$ <u>419,423</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: \$3,822,000 *

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: \$ 2,775 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>Allocation from YAM Management</u>		\$ _____	\$ <u>593</u>	17
18	<u>Allocation from YAM Consulting</u>			<u>3,192</u>	18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>3,785</u>	21

10. Effective dates of current rental agreement:

Beginning 1/01/08

Ending 12/31/12

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

Fiscal Year Ending Annual Rent

12. /2011 \$ _____

13. /2012 \$ _____

14. /2013 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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	\$		\$ 114,498	\$		\$ 114,498	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			6,894			6,894	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			37,139			37,139	4
5	Physician Care	39 - 03	visits			556			556	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				60,472		60,472	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>						17,843		17,843	13
14	TOTAL			\$		\$ 159,087	\$ 78,315		\$ 237,402	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 **Plaza Nursing and Rehab Center**# **0049858**Report Period Beginning: **01/01/10**

Ending:

12/31/10**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/10**

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 41,867	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	398,056		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,454		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	173,500		8
9	Other(specify): See Attached Schedule	110,795		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 738,672	\$	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	227,307		15
16	Equipment, at Historical Cost	51,671		16
17	Accumulated Depreciation (book methods)	(157,563)		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	160,333		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 281,748	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,020,420	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 188,313	\$	26
27	Officer's Accounts Payable	191		27
28	Accounts Payable-Patient Deposits	1,890		28
29	Short-Term Notes Payable	271,796		29
30	Accrued Salaries Payable	105,741		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,509		31
32	Accrued Real Estate Taxes(Sch.IX-B)	121,574		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached Schedule	29,759		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 728,773	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 728,773	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 291,647	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,020,420	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 88,184	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 88,186	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	5,699	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	(102,238)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Capital Contributions	300,000	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 203,461	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)	\$ 291,647	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plaza Nursing and Rehab Center

0049858

Report Period Beginning: 01/01/10

Ending: 12/31/10

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,995,588	1
2	Discounts and Allowances for all Levels	(179,492)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,816,096	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	387,849	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 387,849	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	53,526	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,408	19
20	Radiology and X-Ray	690	20
21	Other Medical Services	2,742	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 61,366	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	140	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 140	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	2,339	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,339	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,267,790	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	715,278	31
32	Health Care	1,369,778	32
33	General Administration	894,953	33
B. Capital Expense			
34	Ownership	749,406	34
C. Ancillary Expense			
35	Special Cost Centers	482,853	35
36	Provider Participation Fee	49,823	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,262,091	40
41	Income before Income Taxes (line 30 minus line 40)**	5,699	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 5,699	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 Plaza Nursing and Rehab Center

0049858

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,989	2,186	\$ 78,825	\$ 36.06	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,285	4,647	132,678	28.55	3
4	Licensed Practical Nurses	15,298	16,128	408,200	25.31	4
5	CNAs & Orderlies	35,830	38,296	390,203	10.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,943	1,989	27,840	14.00	9
10	Activity Assistants	2,914	3,158	30,040	9.51	10
11	Social Service Workers	3,651	3,885	64,828	16.69	11
12	Dietician					12
13	Food Service Supervisor	2,520	2,594	37,673	14.52	13
14	Head Cook	4,131	4,516	58,894	13.04	14
15	Cook Helpers/Assistants	7,257	7,968	74,296	9.32	15
16	Dishwashers					16
17	Maintenance Workers	2,220	2,306	34,419	14.93	17
18	Housekeepers	12,447	13,351	140,505	10.52	18
19	Laundry	1,864	2,129	28,397	13.34	19
20	Administrator	2,125	2,264	84,281	37.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,628	7,046	85,616	12.15	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,917	2,087	64,473	30.89	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,493	2,830	54,368	19.21	33
34	TOTAL (lines 1 - 33)	109,512	117,380	\$ 1,795,536 *	\$ 15.30	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	344	\$ 15,428	01-03	35
36	Medical Director	Monthly	15,250	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	1,956	95,671	10-03	38
39	Pharmacist Consultant	53	5,333	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	69	3,452	11-03	44
45	Social Service Consultant	36	2,060	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,458	\$ 137,194		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	
Gloria Green (1/1/2010 - 11/1/2010)	Administrator	0	\$ 69,591	Workers' Compensation Insurance	\$ 32,350	IDPH License Fee	\$	
Nikki Dinsmore (11/1/10 - 12/31/10)	Administrator	0	14,690	Unemployment Compensation Insurance	68,247	Advertising: Employee Recruitment	520	
				FICA Taxes	133,099	Health Care Worker Background Check	2,130	
				Employee Health Insurance	47,658	(Indicate # of checks performed <u>213</u>)		
				Employee Meals	14,345	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	3,688	
				Pension Plan Contributions	12,574	License & Fees	2,331	
				Other Employee Benefits	296	Allocated from YAM Management	236	
						Allocated from YAM Consulting	43	
						See Supplemental Schedule	5,219	
						Less: Public Relations Expense	()	
						Non-allowable advertising	(5,138)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 84,281					
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 308,570	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 9,029	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Administrative Consulting - YAM Consulting			\$ 24,000				Out-of-State Travel	\$
Management Fees - Yosef Meystel			13,000					
Management Fees - David Berkowitz			21,000				In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 58,000				Seminar Expense	520
							Allocated from YAM Management	285
							Allocated from YAM Consulting	563
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 162,524	TOTAL		\$	TOTAL	\$ 1,368

* 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	FY2007	FY2008	FY2009	FY2010
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$							
2																				
3																				
4																				
5																				
6																				
7																				
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18																				
19																				
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$							

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Plaza Nursing and Rehab Center

0049858

Report Period Beginning:

01/01/10

Ending:

12/31/10

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC: \$5,992.35 IAHC: \$1,092
- (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. \$ 4,613 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 49,823
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. \$ 14,345 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? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.