



Facility Name & ID Number Evanston Nursing & Rehab Center

# 0048454 Report Period Beginning: 01/01/12 Ending: 12/31/12

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>57</u>	Skilled (SNF)	<u>57</u>	<u>20,862</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>57</u>	TOTALS	<u>57</u>	<u>20,862</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	4 Private Pay	Other	Total		
8	SNF	<u>1,945</u>	<u>93</u>	<u>2,493</u>	<u>4,531</u>	8	
9	SNF/PED					9	
10	ICF	<u>14,326</u>	<u>336</u>	<u>655</u>	<u>15,317</u>	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>16,271</u>	<u>429</u>	<u>3,148</u>	<u>19,848</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.14%

D. How many bed-hold days during this year were paid by the Department? 19 (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 09/08/2006

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 57 and days of care provided 2,408

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

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

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

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

**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
	<b>A. General Services</b>										
1	Dietary	125,179	7,389	10,725	143,293		143,293	3,904	147,197		1
2	Food Purchase		91,376		91,376		91,376	(20)	91,356		2
3	Housekeeping	53,296	7,372		60,668		60,668		60,668		3
4	Laundry	19,856	5,599		25,455		25,455		25,455		4
5	Heat and Other Utilities			49,763	49,763		49,763	(4,952)	44,811		5
6	Maintenance	35,521	9,321	61,040	105,882		105,882	(18,646)	87,236		6
7	Other (specify):*							721	721		7
8	<b>TOTAL General Services</b>	233,852	121,057	121,528	476,437		476,437	(18,993)	457,444		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	929,300	61,604	67,604	1,058,508		1,058,508	7,878	1,066,386		10
10a	Therapy										10a
11	Activities	43,389	3,310	587	47,286		47,286		47,286		11
12	Social Services	39,457		1,631	41,088		41,088		41,088		12
13	CNA Training										13
14	Program Transportation			75	75		75	814	889		14
15	Other (specify):*							2,463	2,463		15
16	<b>TOTAL Health Care and Programs</b>	1,012,146	64,914	81,897	1,158,957		1,158,957	11,155	1,170,112		16
	<b>C. General Administration</b>										
17	Administrative	78,638		50,004	128,642		128,642	(75,946)	52,696		17
18	Directors Fees										18
19	Professional Services			173,954	173,954	(185)	173,769	(126,864)	46,905		19
20	Dues, Fees, Subscriptions & Promotions			45,329	45,329		45,329	(24,689)	20,640		20
21	Clerical & General Office Expenses	25,830		55,246	81,076		81,076	(8,121)	72,955		21
22	Employee Benefits & Payroll Taxes			232,331	232,331		232,331		232,331		22
23	Inservice Training & Education										23
24	Travel and Seminar			922	922		922	636	1,558		24
25	Other Admin. Staff Transportation			595	595		595	698	1,293		25
26	Insurance-Prop.Liab.Malpractice			61,367	61,367		61,367	3,105	64,472		26
27	Other (specify):*							9,694	9,694		27
28	<b>TOTAL General Administration</b>	104,468		619,748	724,216	(185)	724,031	(221,487)	502,544		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,350,466	185,971	823,173	2,359,610	(185)	2,359,425	(229,325)	2,130,100		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 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	
	<b>D. Ownership</b>											
30	Depreciation			63,280	63,280		63,280	69,474	132,754			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			34,953	34,953		34,953	166,869	201,822			32
33	Real Estate Taxes					185	185	117,476	117,661			33
34	Rent-Facility & Grounds			449,500	449,500		449,500	(449,500)				34
35	Rent-Equipment & Vehicles			3,644	3,644		3,644	2,020	5,664			35
36	Other (specify):*							35,250	35,250			36
37	<b>TOTAL Ownership</b>			551,377	551,377	185	551,562	(58,411)	493,151			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		99,891	297,417	397,308		397,308		397,308			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			217,352	217,352		217,352		217,352			42
43	Other (specify):*	5,750		190,894	196,644		196,644	(196,644)	0			43
44	<b>TOTAL Special Cost Centers</b>	5,750	99,891	705,663	811,304		811,304	(196,644)	614,660			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,356,216	285,862	2,080,213	3,722,291		3,722,291	(484,380)	3,237,911			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(5,354)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	20,667	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	(20)	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	(715)	21		18
19	Entertainment	(6,650)	21		19
20	Contributions	(23,600)	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	(25,036)	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	(244,010)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (284,718)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	(199,662)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (199,662)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (484,380)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Evanston Nursing & Rehab Center

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing Salaries	\$ (5,750)	43	1
2	Marketing - Advertising/Promotional	(2,319)	43	2
3	Non Allowable Expense	(176,381)	43	3
4	Bank Charges	(6,439)	21	4
5	COPE Dues	(1,489)	20	5
6	Jury Duty Income	(17)	21	6
7	Vending Income	(600)	21	7
8	Additional R&M	5,243	06	8
9	Capitalized R&M	(25,576)	06	9
10	Non Allowable Marketing/Professional Fees	(6,194)	43	10
11	Non Allowable Legal	(9,779)	19	11
12	Bldg Co. - Amortization	(12,860)	31	12
13	Bldg Co. - Bank Charges	(99)	21	13
14	Bldg Co. - Accounting Fees	(1,500)	19	14
15	Bldg Co. - Licenses & Fees	(250)	19	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	<b>Total</b>	(244,010)		49

Evanston Nursing & Rehab Center

ID# 0048454  
 Report Period Beginning: 01/01/12  
 Ending: 12/31/12

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

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Evanston Nursing & Rehab Center# 0048454

Report Period Beginning:

01/01/12

Ending:

12/31/12

## 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				3,904								3,904	1
2	Food Purchase	(20)											(20)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(5,354)		402									(4,952)	5
6	Maintenance	(20,333)		774	913								(18,646)	6
7	Other (specify):*			59	662								721	7
8	<b>TOTAL General Services</b>	<b>(25,707)</b>		<b>1,235</b>	<b>5,479</b>								<b>(18,993)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records				7,878								7,878	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation				814								814	14
15	Other (specify):*				2,463								2,463	15
16	<b>TOTAL Health Care and Programs</b>				<b>11,155</b>								<b>11,155</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			10,817	(86,763)								(75,946)	17
18	Directors Fees													18
19	Professional Services	(11,529)	1,750	(105,834)	(11,315)	64							(126,864)	19
20	Fees, Subscriptions & Promotions	(25,089)		344	37	19							(24,689)	20
21	Clerical & General Office Expenses	(39,556)	99	28,243	3,093								(8,121)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			141	495								636	24
25	Other Admin. Staff Transportation			471	227								698	25
26	Insurance-Prop.Liab.Malpractice		2,405	700									3,105	26
27	Other (specify):*			7,477	2,217								9,694	27
28	<b>TOTAL General Administration</b>	<b>(76,174)</b>	<b>4,254</b>	<b>(57,641)</b>	<b>(92,009)</b>	<b>83</b>							<b>(221,487)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(101,881)</b>	<b>4,254</b>	<b>(56,406)</b>	<b>(75,375)</b>	<b>83</b>							<b>(229,325)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Evanston Nursing & Rehab Center# 0048454

Report Period Beginning:

01/01/12

Ending:

12/31/12

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	20,667	46,674	591		1,542							69,474	30
31	Amortization of Pre-Op. & Org.	(12,860)	12,860											31
32	Interest		164,585	754		1,530							166,869	32
33	Real Estate Taxes		115,745			1,731							117,476	33
34	Rent-Facility & Grounds		(437,500)	(5,779)		(6,221)							(449,500)	34
35	Rent-Equipment & Vehicles			818	1,202								2,020	35
36	Other (specify):*		35,250										35,250	36
37	<b>TOTAL Ownership</b>	<b>7,807</b>	<b>(62,386)</b>	<b>(3,616)</b>	<b>1,202</b>	<b>(1,418)</b>							<b>(58,411)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(190,644)			(6,000)								(196,644)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(190,644)</b>			<b>(6,000)</b>								<b>(196,644)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(284,718)	(58,132)	(60,022)	(80,173)	(1,335)							(484,380)	45

**VII. RELATED PARTIES**

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

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

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  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)		
1	V	34 Rent	\$ 437,500	Evanston NRC Realty	100.00%	\$	(437,500)	1	
2	V	32 Interest	1,531	Evanston NRC Realty	100.00%	166,116	164,585	2	
3	V	31 Amortization		Evanston NRC Realty	100.00%	12,860	12,860	3	
4	V	21 Bank Charges		Evanston NRC Realty	100.00%	99	99	4	
5	V	30 Depreciation		Evanston NRC Realty	100.00%	46,674	46,674	5	
6	V	36 Insurance - MIP		Evanston NRC Realty	100.00%	35,250	35,250	6	
7	V	26 Insurance Expense		Evanston NRC Realty	100.00%	2,405	2,405	7	
8	V	33 Real Estate Taxes		Evanston NRC Realty	100.00%	115,745	115,745	8	
9	V	19 Accounting Fees		Evanston NRC Realty	100.00%	1,500	1,500	9	
10	V	19 Legal Fees		Evanston NRC Realty	100.00%	250	250	10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$ 439,031			\$ 380,899	\$ *	(58,132)	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%	\$ 402	\$	402	15
16	V	6 REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	774		774	16
17	V	7 EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	59		59	17
18	V	17 ADMINISTRATIVE		YAM MANAGEMENT, LLC	100.00%	10,817		10,817	18
19	V	19 PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	666		666	19
20	V	20 FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	344		344	20
21	V	21 CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	28,243		28,243	21
22	V	24 SEMINARS		YAM MANAGEMENT, LLC	100.00%	141		141	22
23	V	25 AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	471		471	23
24	V	26 INSURANCE		YAM MANAGEMENT, LLC	100.00%	700		700	24
25	V	27 EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	7,477		7,477	25
26	V	30 DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	591		591	26
27	V	32 INTEREST		YAM MANAGEMENT, LLC	100.00%	754		754	27
28	V	33 REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%				28
29	V	34 RENT		YAM MANAGEMENT, LLC	100.00%	6,221		6,221	29
30	V	35 AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	710		710	30
31	V	35 EQUIPMENT RENTAL		YAM MANAGEMENT, LLC	100.00%	108		108	31
32	V	0		YAM MANAGEMENT, LLC	100.00%				32
33	V								33
34	V								34
35	V	19 BOOKKEEPING FEES	70,500	YAM MANAGEMENT, LLC	100.00%			(70,500)	35
36	V	19 ACCOUNTING	36,000	YAM MANAGEMENT, LLC	100.00%			(36,000)	36
37	V	34 RENT	12,000	YAM MANAGEMENT, LLC	100.00%			(12,000)	37
38	V								38
39	Total		\$ 118,500			\$ 58,478	\$ *	(60,022)	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	<u>1</u> <u>DIETARY</u>	\$	<u>YAM CONSULTING, LLC</u>	100.00%	\$ 3,904	\$ 3,904
16	V	<u>7</u> <u>EMP. BEN. GEN. SERV.</u>		<u>YAM CONSULTING, LLC</u>	100.00%	662	662
17	V	<u>10</u> <u>NURSING SALARY</u>		<u>YAM CONSULTING, LLC</u>	100.00%	18,603	18,603
18	V	<u>14</u> <u>PROGRAM TRANSPORTATION</u>		<u>YAM CONSULTING, LLC</u>	100.00%	814	814
19	V	<u>15</u> <u>EMP. BEN. HEALTHCARE</u>		<u>YAM CONSULTING, LLC</u>	100.00%	2,463	2,463
20	V	<u>17</u> <u>ADMINISTRATIVE</u>		<u>YAM CONSULTING, LLC</u>	100.00%	10,041	10,041
21	V	<u>19</u> <u>PROFESSIONAL FEES</u>		<u>YAM CONSULTING, LLC</u>	100.00%	168	168
22	V	<u>20</u> <u>FEES, SUBSCRIPTIONS</u>		<u>YAM CONSULTING, LLC</u>	100.00%	37	37
23	V	<u>21</u> <u>CLERICAL &amp; GENERAL</u>		<u>YAM CONSULTING, LLC</u>	100.00%	3,093	3,093
24	V	<u>24</u> <u>SEMINARS</u>		<u>YAM CONSULTING, LLC</u>	100.00%	495	495
25	V	<u>25</u> <u>AUTO AND TRAVEL</u>		<u>YAM CONSULTING, LLC</u>	100.00%	227	227
26	V	<u>27</u> <u>EMP. BEN.-GEN. ADMIN.</u>		<u>YAM CONSULTING, LLC</u>	100.00%	2,217	2,217
27	V	<u>30</u> <u>DEPRECIATION</u>		<u>YAM CONSULTING, LLC</u>	100.00%		
28	V	<u>35</u> <u>AUTO RENTAL</u>		<u>YAM CONSULTING, LLC</u>	100.00%	1,202	1,202
29	V	<u>6</u> <u>REPAIRS AND MAINTENANCE SALARY</u>		<u>YAM CONSULTING, LLC</u>	100.00%	913	913
30	V						
31	V						
32	V	<u>0</u>					
33	V	<u>10</u> <u>DIETICIAN CONSULTING</u>	10,725	<u>YAM CONSULTING, LLC</u>	100.00%		(10,725)
34	V	<u>17</u> <u>NURSE CONSULTING</u>	64,800	<u>YAM CONSULTING, LLC</u>	100.00%		(64,800)
35	V	<u>17</u> <u>DIR. OF OPERATIONS CONSULT</u>	32,004	<u>YAM CONSULTING, LLC</u>	100.00%		(32,004)
36	V	<u>19</u> <u>DATA PROCESSING FEES</u>	11,483	<u>YAM CONSULTING, LLC</u>	100.00%		(11,483)
37	V	<u>43</u> <u>MARKETING</u>	6,000	<u>YAM CONSULTING, LLC</u>	100.00%		(6,000)
38	V						
39	Total		\$ 125,012			\$ 44,839	\$ * (80,173)

\* 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	19 PROFESSIONAL FEES	\$	8131 N. MONTICELLO, LLC	100.00%	\$ 64	\$	64	15
16	V	20 DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		19		19	16
17	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC					17
18	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC		1,542		1,542	18
19	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC		1,530		1,530	19
20	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		1,731		1,731	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34 RENT	6,221	8131 N. MONTICELLO, LLC				(6,221)	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		\$ 6,221			\$ 4,886	\$ *	(1,335)	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	39

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	1219 LIMITED PARTNERSHIP	7.500%	BERKSHIRE NURSING & REHAB CENTER,LLC	FOREST PARK	EVANSTON NRC REALTY, LLC	SKOKIE	BUILDING CO.	1
2	257 LIMITED PARTNERSHIP	7.500%	CONCORD NURSING AND REHABILITATION CENTER,LLC	OAK LAWN	YAM MANAGEMENT	SKOKIE	MANAGEMENT CO.	2
3	42170 LIMITED PARTNERSHIP	7.500%	DOLTON NURSING & REHAB,LLC	DOLTON	YAM CONSULTING	SKOKIE	CONSULTING CO.	3
4	BARRY ROSEBLUM	2.500%	EXCEPTIONAL CARE, LLC	BURBANK	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDIN	4
5	DAVID KLEINER	3.750%	FAIRVIEW CARE CENTER OF JOLIET,LLC	JOLIET				5
6	DENNIS RUBEN	3.500%	HIGHLAND PARK NURSING AND REHAB CENTER, LLC	HIGHWOOD				6
7	GARY BIDER	3.750%	INTERNATIONAL NURSING & REHAB CENTER,LLC	CHICAGO				7
8	JOYCE RUBEN	3.500%	LITCHFIELD CARE CENTER,LLC	LITCHFIELD				8
9	ZAXHARY RUBEN	1.500%	NORTH CHURCH NURSING & REHAB,LLC	JACKSONVILLE				9
10	MARLEE ASSOCIATES, LLC	4.250%	PLAZA NURSING AND REHAB CENTER,LLC	MIDLOTHIAN				10
11	MICHAEL ROSEN	2.000%	PLUM GROVE NURSING AND REHAB,LLC	PALATINE				11
12	MOSHE EPSTEIN	0.750%	RIVIERA CARE CENTER,LLC	CHICAGO HEIGHTS				12
13	RACHEL CHAVIN	4.750%	SPRINGFIELD CARE CENTER,LLC	SPRINGFIELD				13
14	REBECCA LAFER	3.000%	THE ARBORS AT MICHIGAN CITY	MICHIGAN CITY,IN				14
15	SERENA ESFORMES	2.500%	THE COPPERAS HOLLOW	CALDWELL, TX				15
16	DECLARATION OF TRUST OF YOSEF MEYSTEL	38.578%						16
17	JOEL MEYSTEL	1.672%						17
18	LAURA DAVIDOWITZ REVOCABLE TRUST	1.500%						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

**VII. RELATED PARTIES**

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

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

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

## 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	Relative	Administrative	0.00%	See Attached	1.2	3.00%	Mgmt. Fees	\$ 18,000	17-03	1
2	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.6	1.50%	Alloc. Salary	1,822	17-07	2
3	Joel Meystel	Shareholder	Administrative	1.67%	See Attached	0.6	3.00%	Alloc. Salary	685	17-07	3
4	Cynthia Meystel	Relative	Administrative	0.00%	See Attached	0.1	3.03%	Alloc. Salary	137	21-07	4
5											5
6											6
7											7
8											8
9	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										9
10	anticipated to be considered allowable by the IL. Dept. of HFS.										10
11											11
12											12
13								TOTAL	\$ 20,644		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 Evanston Nursing & Rehab Center

# 0048454

Report Period Beginning:

01/01/12

Ending: 12/31/12

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center

# 0048454

Report Period Beginning:

01/01/12

Ending: 12/31/12

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	697,482	17	\$ 13,451	\$ 20,862	\$ 402	1	
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	697,482	17	25,882	8,567	20,862	774	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	697,482	17	1,974		20,862	59	3
4	17	ADMINISTRATIVE	AVAIL. BED DAYS	697,482	17	361,644	361,644	20,862	10,817	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	697,482	17	22,257		20,862	666	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	697,482	17	11,509		20,862	344	6
7	21	CLERICAL & GENERAL	AVAIL. BED DAYS	697,482	17	944,249	887,220	20,862	28,243	7
8	24	SEMINARS	AVAIL. BED DAYS	697,482	17	4,715		20,862	141	8
9	25	AUTO AND TRAVEL	AVAIL. BED DAYS	697,482	17	15,759		20,862	471	9
10	26	INSURANCE	AVAIL. BED DAYS	697,482	17	23,390		20,862	700	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	697,482	17	249,963		20,862	7,477	11
12	30	DEPRECIATION	AVAIL. BED DAYS	697,482	17	19,767		20,862	591	12
13	32	INTEREST	AVAIL. BED DAYS	697,482	17	25,195		20,862	754	13
14	33	REAL ESTATE TAX	AVAIL. BED DAYS	697,482	17	-		20,862		14
15	34	RENT	AVAIL. BED DAYS	697,482	17	208,000		20,862	6,221	15
16	35	AUTO RENTAL	AVAIL. BED DAYS	697,482	17	23,725		20,862	710	16
17	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	697,482	17	3,615		20,862	108	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,955,095	\$ 1,257,431	\$ 58,478		25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center

# 0048454

Report Period Beginning:

01/01/12

Ending: 12/31/12

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	697,482	17	\$ 130,530	\$ 122,357	20,862	\$ 3,904	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	697,482	17	22,148		20,862	662	2
3	10	NURSING SALARY	AVAIL. BED DAYS	697,482	17	621,969	621,969	20,862	18,603	3
4	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	697,482	17	27,214		20,862	814	4
5	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	697,482	17	82,340		20,862	2,463	5
6	17	ADMINISTRATIVE	AVAIL. BED DAYS	697,482	17	335,714	335,714	20,862	10,041	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	697,482	17	5,608		20,862	168	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	697,482	17	1,231		20,862	37	8
9	21	CLERICAL & GENERAL	AVAIL. BED DAYS	697,482	17	103,402	93,384	20,862	3,093	9
10	24	SEMINARS	AVAIL. BED DAYS	697,482	17	16,540		20,862	495	10
11	25	AUTO AND TRAVEL	AVAIL. BED DAYS	697,482	17	7,585		20,862	227	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	697,482	17	74,111		20,862	2,217	12
13	30	DEPRECIATION	AVAIL. BED DAYS	697,482	17	-		20,862		13
14	35	AUTO RENTAL	AVAIL. BED DAYS	697,482	17	40,201		20,862	1,202	14
15	6	REPAIRS AND MAINTENANCE	AVAIL. BED DAYS	697,482	17	30,518		20,862	913	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,499,111	\$ 1,173,424		\$ 44,839	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center

# 0048454

Report Period Beginning:

01/01/12

Ending: 12/31/12

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	19	PROFESSIONAL FEES	AVAIL. BED DAYS	697,482	17	\$ 2,136	\$ 20,862	\$ 64	1
2	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	697,482	17	645	20,862	19	2
3	21	OFFICE EXPENSE	AVAIL. BED DAYS	697,482	17	-	20,862		3
4	30	DEPRECIATION	AVAIL. BED DAYS	697,482	17	51,541	20,862	1,542	4
5	32	INTEREST EXPENSE	AVAIL. BED DAYS	697,482	17	51,147	20,862	1,530	5
6	33	REAL ESTATE TAXES	AVAIL. BED DAYS	697,482	17	57,872	20,862	1,731	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					\$ 163,341	\$	\$ 4,886	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center

# 0048454

Report Period Beginning:

01/01/12

Ending: 12/31/12

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center

# 0048454

Report Period Beginning:

01/01/12

Ending: 12/31/12

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center

# 0048454

Report Period Beginning:

01/01/12

Ending: 12/31/12

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center

# 0048454

Report Period Beginning:

01/01/12

Ending: 12/31/12

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center

# 0048454 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Evanston Nursing & Rehab Center

# 0048454

Report Period Beginning:

01/01/12

Ending: 12/31/12

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Evanston Nursing & Rehab Center

# 0048454

Report Period Beginning:

01/01/12

Ending:

12/31/12

**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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Bldg Co. - Mortgage Payable		X	Mortgage Payable			\$	\$ 4,258,864		\$ 166,116	1								
2											2								
3											3								
4											4								
5	See Supplemental Schedule										5								
<b>Working Capital</b>																			
6	Lake Forest Bank & Trust Co.		X	Line of Credit				656,860		34,072	6								
7	Insurance Policies		X							881	7								
8	See Supplemental Schedule									2,284	8								
9	<b>TOTAL Facility Related</b>					\$	\$ 4,915,724			\$ 203,353	9								
<b>B. Non-Facility Related*</b>																			
10	Bldg Co. - Interest Income		X							(1,531)	10								
11											11								
12											12								
13	See Supplemental Schedule										13								
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$ (1,531)	14								
15	<b>TOTALS (line 9+line14)</b>					\$	\$ 4,915,724			\$ 201,822	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 35,250 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Evanston Nursing & Rehab Center

# 0048454

Report Period Beginning:

01/01/12

Ending:

12/31/12

**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										
										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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1										1									
2										2									
3										3									
4										4									
5										5									
6										6									
7	<b>TOTAL Long-Term</b>																		
<b>Working Capital</b>																			
8	Allocated Yam Mgmt	X								754									
9	Allocated 8131 N. Monticello	X								1,530									
10										10									
11										11									
12										12									
13										13									
14	<b>TOTAL Working Capital</b>																		
<b>B. Non-Facility Related*</b>																			
15										15									
16										16									
17										17									
18										18									
19										19									
20	<b>TOTAL Non-Facility Related</b>																		

\* 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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>																						
1. Real Estate Tax accrual used on 2011 report.		\$	<b>111,808</b>	<b>1</b>																				
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.)		\$	<b>114,085</b>	<b>2</b>																				
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>2,277</b>	<b>3</b>																				
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>115,200</b>	<b>4</b>																				
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>185</b>	<b>5</b>																				
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>																				
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>117,662</b>	<b>7</b>																				
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:	2007	<b>100,729</b>	<b>8</b>	<table border="1" style="width: 100%;"> <tr> <td colspan="3" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;"><b>13</b></td> <td>FROM R. E. TAX STATEMENT FOR 2011</td> <td style="text-align: right;">\$</td> <td style="text-align: center;"><b>13</b></td> </tr> <tr> <td style="text-align: center;"><b>14</b></td> <td>PLUS APPEAL COST FROM LINE 5</td> <td style="text-align: right;">\$</td> <td style="text-align: center;"><b>14</b></td> </tr> <tr> <td style="text-align: center;"><b>15</b></td> <td>LESS REFUND FROM LINE 6</td> <td style="text-align: right;">\$</td> <td style="text-align: center;"><b>15</b></td> </tr> <tr> <td style="text-align: center;"><b>16</b></td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td style="text-align: right;">\$</td> <td style="text-align: center;"><b>16</b></td> </tr> </table>		<b>FOR BHF USE ONLY</b>			<b>13</b>	FROM R. E. TAX STATEMENT FOR 2011	\$	<b>13</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>
<b>FOR BHF USE ONLY</b>																								
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2011	\$	<b>13</b>																					
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>																					
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>																					
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>																					
	2008	<b>104,597</b>	<b>9</b>																					
	2009	<b>73,669</b>	<b>10</b>																					
	2010	<b>111,808</b>	<b>11</b>																					
	2011	<b>112,354</b>	<b>12</b>																					
<b>2012 Accrual - 2011 R/E Tax x 2.5%</b>																								
<b>Allocated from 8131 N. Monticello - \$1,731</b>																								

**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**

# 2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Evanston Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048454

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(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.	<u>11-18-326-011-0000</u>	<u>Long Term Care Property</u>	\$ <u>112,353.55</u>	\$ <u>112,353.55</u>
2.	<u>10-23-325-045-0000</u>	<u>Allocated from Mgmt Co.</u>	\$ <u>66,065.10</u>	\$ <u>1,730.98</u>
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
<b>TOTALS</b>			\$ <u><u>178,418.65</u></u>	\$ <u><u>114,084.53</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

**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 Evanston Nursing & Rehab Center

# 0048454 Report Period Beginning:

01/01/12 Ending:

12/31/12

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (a) Own the Facility  (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: \_\_\_\_\_ 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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1			<u>2008</u>	\$ <u>286,895</u>	<u>1</u>
2	<u>Allocated from 8131 N. Monticello</u>			<u>2,662</u>	<u>2</u>
3	<b>TOTALS</b>			\$ <u>289,557</u>	<u>3</u>

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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	57		2008	1961	\$ 1,644,650	\$ 46,674	35	\$ 46,990	\$ 316	\$ 130,767	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various		2007		57,689		20	3,639	3,639	31,868	9
10	Various		2008		95,962		20	9,596	9,596	42,709	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 and Improvement Costs-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		18,730			937	937	937	67
68		31,513	1,871		1,112	(759)	2,724	68
69			63,280			(63,280)		69
70		\$ 1,848,543	\$ 111,825		\$ 62,274	\$ (49,551)	\$ 209,005	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Evanston Nursing & Rehab Center# 0048454

Report Period Beginning:

01/01/12

Ending:

12/31/12**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	<b>Totals from Page 12A, Carried Forward</b>		\$ 1,848,543	\$ 111,825		\$ 62,274	\$ (49,551)	\$ 209,005	1
2	Fireplace And Light Installation	2009	4,550		20	455	455	1,744	2
3	Window Treatments; Cubicle Curtains; Chair	2009	15,559		20	1,556	1,556	5,705	3
4	Flooring Sealant, Carpet Removal, New Hardwood Floor	2009	6,900		20	690	690	2,300	4
5	Ground Floor Washroom- Floor And Wall Tiles, Grab Bars	2009	4,425		20	443	443	1,549	5
6	1St & 2Nd Flr Bathrooms- Floor Tiles, Electrical, Paint	2009	17,200		20	1,720	1,720	5,590	6
7	New Elevator Equipment	2009	9,966		20	997	997	3,239	7
8	Acm Elevator	2010	4,415		20	221	221	662	8
9	Window Treatment	2010	3,104		20	621	621	1,862	9
10	Bathrooms - Fixtures, Tile, Flooring, Door, Paint, Lights	2010	16,000		20	800	800	2,400	10
11	Bathrooms - Fixtures, Tile, Flooring, Door, Paint, Lights	2010	4,000		20	200	200	600	11
12	Bathrooms - Fixtures, Tile, Flooring, Door, Paint, Lights	2010	4,000		20	200	200	600	12
13	Bathrooms - Fixtures, Tile, Flooring, Door, Paint, Lights	2010	4,000		20	200	200	583	13
14	Flooring Office	2010	3,121		20	624	624	1,820	14
15	Bathrooms - Fixtures, Tile, Flooring, Door, Paint, Lights	2010	5,256		20	263	263	723	15
16	Light Installation	2010	7,445		20	372	372	931	16
17	Living Room Tile	2010	9,854		20	493	493	1,150	17
18	Overbed Lighting	2010	3,632		20	726	726	1,816	18
19	Built-In Dresser, Cover Lights, Granite Tops, Locks & Installation	2010	31,000		20	1,550	1,550	3,617	19
20	Repair And Paint Walls, Handrails	2010	3,420		20	171	171	413	20
21	Plumbing	2010	4,651		20	233	233	620	21
22	Elevator Paint, Handrail	2011	3,800		20	190	190	333	22
23	Dry Wall Ceiling	2012	4,600		20	153	153	153	23
24	Thermal System Pipe Insulation Removal	2012	2,800		20	140	140	140	24
25	1St Fl Dining Room, 2Nd Fl Oak Room, Stairwell Removal & Clean	2012	18,550		20	928	928	928	25
26	Passage Lever	2012	4,226		20	211	211	211	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,045,017	\$ 111,825		\$ 76,429	\$ (35,396)	\$ 248,693	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 and Improvement Costs-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		\$ 2,045,017	\$ 111,825		\$ 76,429	\$ (35,396)	\$ 248,693	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)	\$ 2,045,017	\$ 111,825		\$ 76,429	\$ (35,396)	\$ 248,693	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 and Improvement Costs-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		\$ 2,045,017	\$ 111,825		\$ 76,429	\$ (35,396)	\$ 248,693	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)	\$ 2,045,017	\$ 111,825		\$ 76,429	\$ (35,396)	\$ 248,693	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 and Improvement Costs-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		\$ 2,045,017	\$ 111,825		\$ 76,429	\$ (35,396)	\$ 248,693	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)	\$ 2,045,017	\$ 111,825		\$ 76,429	\$ (35,396)	\$ 248,693	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Building Company Information</b>								1
2	<b>Buildings:</b>								2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	<b>2 Steel Doors &amp; Frame</b>	2012	4,450		20	223	223	223	9
10	<b>Concrete Patio - Roof &amp; Railing</b>	2012	14,280		20	714	714	714	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 and Improvement Costs-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)	\$ 18,730	\$		\$ 937	\$ 937	\$ 937	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 and Improvement Costs-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	<b>Related Party Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3	<u>Allocated from 8131 N. Monticello, LLC</u>	<u>2010</u>	<u>20,684</u>	<u>615</u>	<u>39</u>	<u>530</u>	<u>(85)</u>	<u>1,304</u>	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	<u>Allocated from 8131 N. Monticello, LLC</u>	<u>2010</u>	<u>9,265</u>	<u>927</u>	<u>20</u>	<u>463</u>	<u>(464)</u>	<u>1,176</u>	9
10									10
11	<u>Allocated from YAM Management, LLC</u>	<u>2010</u>	<u>985</u>	<u>25</u>	<u>20</u>	<u>99</u>	<u>74</u>	<u>224</u>	11
12	<u>Allocated from YAM Management, LLC</u>	<u>2012</u>	<u>579</u>	<u>304</u>	<u>20</u>	<u>20</u>	<u>(284)</u>	<u>20</u>	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 and Improvement Costs-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)	\$ 31,513	\$ 1,871		\$ 1,112	\$ (759)	\$ 2,724	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 453,122	\$ 7	\$ 55,973	\$ 55,966	10	\$ 253,587	71
72	Current Year Purchases	396	244	87	(157)	10	87	72
73	Fully Depreciated Assets	1,388				10	1,388	73
74								74
75	TOTALS	\$ 454,906	\$ 251	\$ 56,060	\$ 55,809		\$ 255,062	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		YAM Management	2009	\$ 1,017	\$ 11	\$ 264	\$ 253	5	\$ 294	76
77										77
78										78
79										79
80	TOTALS			\$ 1,017	\$ 11	\$ 264	\$ 253		\$ 294	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,790,497	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 112,087	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 132,754	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 20,667	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 504,050	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: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			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: \$ 3,752 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>710</u>	17
18	<u>Allocated from YAM Consulting</u>			<u>1,202</u>	18
19					19
20					20
21	TOTAL		\$	<u>1,912</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. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

\* 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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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		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	\$				\$ 109,430	\$			\$ 109,430	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					42,167				42,167	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	39 - 03	hrs					143,941				143,941	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						95,176			95,176	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>							1,879	4,715			6,594	13	
14	TOTAL			\$				\$ 297,417	\$ 99,891			\$ 397,308	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 Evanston Nursing & Rehab Center# 0048454Report Period Beginning: 01/01/12Ending: 12/31/12

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 299,739	\$ 555,212	1
2	Cash-Patient Deposits	51,433	51,433	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	732,743	732,743	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	67,450	72,259	6
7	Other Prepaid Expenses	540	540	7
8	Accounts Receivable (owners or related parties)	665,000	665,000	8
9	Other(specify): <u>See Attached Schedule</u>	685	224,040	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,817,590	\$ 2,301,227	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		286,895	13
14	Buildings, at Historical Cost		764,650	14
15	Leasehold Improvements, at Historical Cost	297,059	315,789	15
16	Equipment, at Historical Cost	249,046	521,984	16
17	Accumulated Depreciation (book methods)	(266,293)	(494,740)	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>	880,000	983,400	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,159,812	\$ 2,377,978	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,977,402	\$ 4,679,205	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 314,156	\$ 314,155	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	56,365	56,365	28
29	Short-Term Notes Payable	656,860	656,860	29
30	Accrued Salaries Payable	133,788	133,788	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,056	6,056	31
32	Accrued Real Estate Taxes(Sch.IX-B)		115,200	32
33	Accrued Interest Payable	3,035	14,747	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>			36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,170,260	\$ 1,297,171	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,258,864	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 4,258,864	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,170,260	\$ 5,556,035	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,807,142	\$ (876,830)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,977,402	\$ 4,679,205	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>673,118</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustment</b>	<b>(10,000)</b>	<b>3</b>
<b>4</b>	<b>Rounding</b>	<b>4</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>663,122</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>779,991</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants	<b>771,330</b>	<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(407,301)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>1,144,020</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,807,142</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Evanston Nursing &amp; Rehab Center

# 0048454

Report Period Beginning: 01/01/12

Ending:

12/31/12

**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**

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,409,469	1
2	Discounts and Allowances for all Levels	(951,053)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,458,416	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	949,803	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 949,803	8
<b>C. Other Operating Revenue</b>			
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	83,699	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,460	19
20	Radiology and X-Ray	420	20
21	Other Medical Services	3,867	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 93,446	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>See Supplemental Schedule</b>	617	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 617	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,502,282	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	476,437	31
32	Health Care	1,158,957	32
33	General Administration	724,216	33
<b>B. Capital Expense</b>			
34	Ownership	551,377	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	593,952	35
36	Provider Participation Fee	217,352	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,722,291	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	779,991	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 779,991	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,965,425	44
45	Private Pay - Net Inpatient Revenue	74,744	45
46	Medicare - Net Inpatient Revenue	278,300	46
47	Other-(specify)	139,947	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 3,458,416	49

\* 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.

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

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number **Evanston Nursing & Rehab Center**

# **0048454**

Report Period Beginning:

**01/01/12**

Ending:

**12/31/12**

**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	1,887	1,949	\$ 76,766	\$ 39.39	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,868	7,744	230,614	29.78	3
4	Licensed Practical Nurses	9,604	10,390	250,611	24.12	4
5	CNAs & Orderlies	26,015	27,963	298,640	10.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,690	3,955	43,389	10.97	10
11	Social Service Workers	1,965	2,146	39,457	18.39	11
12	Dietician					12
13	Food Service Supervisor	1,992	2,092	37,697	18.02	13
14	Head Cook	3,681	3,966	39,700	10.01	14
15	Cook Helpers/Assistants	5,010	5,327	47,782	8.97	15
16	Dishwashers					16
17	Maintenance Workers	1,906	2,137	35,521	16.62	17
18	Housekeepers	5,391	5,731	53,296	9.30	18
19	Laundry	2,079	2,147	19,856	9.25	19
20	Administrator	1,542	1,928	78,638	40.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,936	2,151	25,830	12.01	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	3,104	3,374	72,669	21.54	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	304	304	5,750	18.91	33
34	TOTAL (lines 1 - 33)	76,974	83,304	\$ 1,356,216 *	\$ 16.28	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	195	\$ 10,725	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	1,325	66,228	10-03	38
39	Pharmacist Consultant	Monthly	1,376	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	10	587	11-03	44
45	Social Service Consultant	28	1,631	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,558	\$ 92,547		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		
<u>Etan Bleichman</u>	<u>Administrator</u>	<u>0.00</u>	<u>\$ 78,638</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 51,936</u>	<u>IDPH License Fee</u>	<u>\$</u>		
				<u>Unemployment Compensation Insurance</u>	<u>10,966</u>	<u>Advertising: Employee Recruitment</u>	<u>309</u>		
				<u>FICA Taxes</u>	<u>100,456</u>	<u>Health Care Worker Background Check</u>			
				<u>Employee Health Insurance</u>	<u>55,431</u>	<u>(Indicate # of checks performed <u>349</u>)</u>	<u>3,508</u>		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>			
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues &amp; Subscriptions</u>	<u>9,456</u>		
				<u>Pension Fund</u>	<u>11,327</u>	<u>Licenses &amp; Permits</u>	<u>6,967</u>		
				<u>401K Expense</u>	<u>1,690</u>	<u>Allocated from Yam Consulting</u>	<u>37</u>		
				<u>Other Employee Benefits</u>	<u>525</u>	<u>Allocated from 8131 N. Monticello</u>	<u>19</u>		
						<u>See Supplemental Schedule</u>	<u>344</u>		
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>						<u>Less: Public Relations Expense</u>	<u>( )</u>		
<b>(List each licensed administrator separately.)</b>			<u>\$ 78,638</u>			<u>Non-allowable advertising</u>	<u>( )</u>		
						<u>Yellow page advertising</u>	<u>( )</u>		
<b>B. Administrative - Other</b>									
<b>Description</b>			<b>Amount</b>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>			<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>		
<u>Management Fees - Yosef Meystel</u>			<u>\$ 18,000</u>		<u>\$ 232,331</u>		<u>\$ 20,640</u>		
<u>YAM Consulting, LLC - Administrative Consulting</u>			<u>32,004</u>						
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<u>\$ 50,004</u>	<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>		
<b>(Attach a copy of any management service agreement)</b>				<b>Description</b>	<b>Line #</b>	<b>Amount</b>	<b>Description</b>	<b>Amount</b>	
<b>C. Professional Services</b>							<u>Out-of-State Travel</u>	<u>\$</u>	
<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>							
<u>Frost, Ruttenberg &amp; Rothblatt</u>	<u>Accounting</u>	<u>\$ 15,273</u>							
<u>YAM Management</u>	<u>Accounting</u>	<u>36,000</u>							
<u>Risk Management</u>	<u>Risk Management Services</u>	<u>1,000</u>							
<u>Personnel Planners</u>	<u>Unemployment Consult</u>	<u>1,041</u>							
<u>Pro Payroll Solutions, LLC</u>	<u>Payroll Services</u>	<u>1,625</u>							
<u>SAS Architects &amp; Planners</u>	<u>Architectural Services</u>	<u>1,627</u>							
<u>BYLMAS</u>	<u>Tax Credit Services</u>	<u>360</u>							
<u>Prospect Resources</u>	<u>Energy Service Consult</u>	<u>200</u>							
<u>YAM Management</u>	<u>Bookkeeping</u>	<u>70,500</u>							
<u>YAM Consulting</u>	<u>Data Processing</u>	<u>11,483</u>							
<u>Health Data Systems, Inc.</u>	<u>Data Processing</u>	<u>2,939</u>							
<u>See Supplemental Schedule</u>		<u>31,906</u>							
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<u>\$ 173,954</u>	<b>TOTAL</b>			<u>\$</u>	<u>Seminar Expense</u>	<u>922</u>
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>							<u>Allocated from Yam Management</u>	<u>141</u>	
							<u>Allocated from Yam Consulting</u>	<u>495</u>	
							<u>Entertainment Expense</u>	<u>( )</u>	
							<u>(agree to Sch. V, line 24, col. 8)</u>		
							<b>TOTAL</b>	<u>\$ 1,558</u>	

\* 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																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	<b>TOTALS</b>			\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evanston Nursing & Rehab Center# 0048454

Report Period Beginning:

01/01/12

Ending:

12/31/12**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. ILCLTC: \$6,803
- (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. \$ 17,093 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? X YES        NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES        NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 217,352  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.