

Facility Name & ID Number Highland Park Nursing & Rehab

0048330 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>104</u>	Skilled (SNF)	<u>104</u>	<u>38,064</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>104</u>	TOTALS	<u>104</u>	<u>38,064</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	4 Other	5 Total	
8	SNF	<u>2,243</u>	<u>406</u>	<u>6,333</u>	<u>8,982</u>	8
9	SNF/PED					9
10	ICF	<u>15,481</u>	<u>6,638</u>	<u>1,407</u>	<u>23,526</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,724</u>	<u>7,044</u>	<u>7,740</u>	<u>32,508</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.40%

D. How many bed-hold days during this year were paid by the Department? 237 (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 09/06/06

J. Was the facility purchased or leased after January 1, 1978?
YES Date 09/06/06 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 104 and days of care provided 6,076

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Highland Park Nursing & Rehab # 0048330 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
	A. General Services										
1	Dietary	238,060	22,454	23,704	284,218		284,218	(14,437)	269,781		1
2	Food Purchase		247,172		247,172		247,172	(536)	246,636		2
3	Housekeeping	135,761	19,796		155,557		155,557		155,557		3
4	Laundry	68,611	12,778		81,389		81,389		81,389		4
5	Heat and Other Utilities			127,253	127,253		127,253	(7,909)	119,344		5
6	Maintenance	48,375	9,564	68,670	126,609		126,609	15,694	142,303		6
7	Other (specify):*							1,317	1,317		7
8	TOTAL General Services	490,807	311,764	219,627	1,022,198		1,022,198	(5,871)	1,016,327		8
	B. Health Care and Programs										
9	Medical Director			60,000	60,000		60,000		60,000		9
10	Nursing and Medical Records	1,775,940	184,559	49,126	2,009,625		2,009,625	(10,925)	1,998,700		10
10a	Therapy	2,638			2,638		2,638		2,638		10a
11	Activities	85,817	14,807	2,200	102,824		102,824		102,824		11
12	Social Services	39,037		3,064	42,101		42,101		42,101		12
13	CNA Training										13
14	Program Transportation			4,883	4,883		4,883	1,485	6,368		14
15	Other (specify):*							4,494	4,494		15
16	TOTAL Health Care and Programs	1,903,432	199,366	119,273	2,222,071		2,222,071	(4,946)	2,217,125		16
	C. General Administration										
17	Administrative	110,013		49,500	159,513		159,513	(5,443)	154,070		17
18	Directors Fees										18
19	Professional Services			223,336	223,336		223,336	(162,324)	61,012		19
20	Dues, Fees, Subscriptions & Promotions			54,077	54,077		54,077	(18,620)	35,457		20
21	Clerical & General Office Expenses	92,243		198,774	291,017		291,017	(55,737)	235,280		21
22	Employee Benefits & Payroll Taxes			445,658	445,658		445,658		445,658		22
23	Inservice Training & Education										23
24	Travel and Seminar			767	767		767	1,160	1,927		24
25	Other Admin. Staff Transportation			6,489	6,489		6,489	774	7,263		25
26	Insurance-Prop.Liab.Malpractice			76,014	76,014		76,014	1,276	77,290		26
27	Other (specify):*							17,685	17,685		27
28	TOTAL General Administration	202,256		1,054,615	1,256,871		1,256,871	(221,229)	1,035,642		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,596,495	511,130	1,393,515	4,501,140		4,501,140	(232,045)	4,269,095		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	
	D. Ownership											
30	Depreciation			150,768	150,768		150,768	550,184	700,952			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			62,383	62,383		62,383	869,322	931,705			32
33	Real Estate Taxes			62,864	62,864		62,864	3,158	66,022			33
34	Rent-Facility & Grounds			982,000	982,000		982,000	(982,000)				34
35	Rent-Equipment & Vehicles			7,655	7,655		7,655	3,686	11,341			35
36	Other (specify):*											36
37	TOTAL Ownership			1,265,670	1,265,670		1,265,670	444,350	1,710,020			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		298,288	688,957	987,245		987,245	(28,027)	959,218			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			338,756	338,756		338,756		338,756			42
43	Other (specify):*	125,692		108,511	234,203		234,203	(234,203)	0			43
44	TOTAL Special Cost Centers	125,692	298,288	1,136,224	1,560,204		1,560,204	(262,230)	1,297,974			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,722,187	809,418	3,795,409	7,327,014		7,327,014	(49,925)	7,277,089			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(100)	21		4
5	Telephone, TV & Radio in Resident Rooms	(8,643)	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	(344,748)	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	(536)	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	(2,983)	21		18
19	Entertainment	(3,010)	21		19
20	Contributions	(19,350)	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	(95,620)	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	(281,370)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (756,360)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	706,435		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 706,435		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (49,925)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Highland Park Nursing & Rehab

	ID#	0048330
Report Period Beginning:		01/01/12
Ending:		12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Pharmacy - Veterans	\$ (318)	10	1
2	Advertising - Marketing	(34,282)	43	2
3				3
4	Promotional Products	(9,229)	43	4
5	Bank Charges	(9,615)	21	5
6	Jury Duty Income	(75)	21	6
7	Other Unclassified Income	(195)	21	7
8	Vending Income	(1,313)	21	8
9	Additional R&M	12,617	06	9
10	Marketing Salaries	(125,692)	43	10
11	Non Allowable Legal	(22,401)	19	11
12	Bldg Co. - Licenses & Permits	(250)	20	12
13	Bldg Co. - Amortization	(24,402)	36	13
14	Bldg Co. - Bank Charges	(93)	21	14
15	Bldg Co. - Legal Fees	(1,123)	19	15
16	Bldg Co. - Accounting Fees	(5,500)	19	16
17	Non Allowable Travel	(500)	25	17
18	Non Allowable Expense	(59,000)	43	18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(281,370)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Highland Park Nursing & Rehab# 0048330

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				(14,437)								(14,437)	1
2	Food Purchase	(536)											(536)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(8,643)		734									(7,909)	5
6	Maintenance	12,617		1,412	1,665								15,694	6
7	Other (specify):*			108	1,209								1,317	7
8	TOTAL General Services	3,438		2,254	(11,563)								(5,871)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(318)			(10,607)								(10,925)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation				1,485								1,485	14
15	Other (specify):*				4,494								4,494	15
16	TOTAL Health Care and Programs	(318)			(4,628)								(4,946)	16
	C. General Administration													
17	Administrative			19,736	(25,179)								(5,443)	17
18	Directors Fees													18
19	Professional Services	(29,024)	6,623	(121,282)	(18,758)	117							(162,324)	19
20	Fees, Subscriptions & Promotions	(19,600)	250	628	67	35							(18,620)	20
21	Clerical & General Office Expenses	(113,004)	93	51,531	5,643								(55,737)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			257	903								1,160	24
25	Other Admin. Staff Transportation	(500)		860	414								774	25
26	Insurance-Prop.Liab.Malpractice			1,276									1,276	26
27	Other (specify):*			13,641	4,044								17,685	27
28	TOTAL General Administration	(162,128)	6,966	(33,353)	(32,866)	152							(221,229)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(159,007)	6,966	(31,099)	(49,057)	152							(232,045)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Highland Park Nursing & Rehab# 0048330

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)	
	D. Ownership													
30	Depreciation	(344,748)	891,040	1,079		2,813							550,184	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		865,156	1,375		2,791							869,322	32
33	Real Estate Taxes					3,158							3,158	33
34	Rent-Facility & Grounds		(970,000)	(649)		(11,351)							(982,000)	34
35	Rent-Equipment & Vehicles			1,492	2,194								3,686	35
36	Other (specify):*	(24,402)	24,402											36
37	TOTAL Ownership	(369,150)	810,598	3,297	2,194	(2,589)							444,350	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(28,027)						(28,027)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(228,203)			(6,000)								(234,203)	43
44	TOTAL Special Cost Centers	(228,203)			(6,000)		(28,027)						(262,230)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(756,360)	817,564	(27,802)	(52,863)	(2,437)	(28,027)						(49,925)	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 Page 6 Supp.		See Page 6 Supp.		See Page 6 Supp.		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 970,000	Highland Park NRC Realty, LLC	100.00%	\$	(970,000)	1
2	V	33 Real Estate Taxes	62,863	Highland Park NRC Realty, LLC	100.00%	62,863		2
3	V	32 Interest	116	Highland Park NRC Realty, LLC	100.00%	865,272	865,156	3
4	V	20 Licenses & Permits		Highland Park NRC Realty, LLC	100.00%	250	250	4
5	V	36 Amortization - Loan Fees		Highland Park NRC Realty, LLC	100.00%	24,402	24,402	5
6	V	21 Bank Charges		Highland Park NRC Realty, LLC	100.00%	93	93	6
7	V	30 Depreciation		Highland Park NRC Realty, LLC	100.00%	891,040	891,040	7
8	V	19 Legal		Highland Park NRC Realty, LLC	100.00%	1,123	1,123	8
9	V	19 Accounting Fees		Highland Park NRC Realty, LLC	100.00%	5,500	5,500	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,032,979			\$ 1,850,543	\$ * 817,564	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%	\$ 734	\$	734	15
16	V	6 REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	1,412		1,412	16
17	V	7 EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	108		108	17
18	V	17 ADMINISTRATIVE		YAM MANAGEMENT, LLC	100.00%	19,736		19,736	18
19	V	19 PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	1,215		1,215	19
20	V	20 FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	628		628	20
21	V	21 CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	51,531		51,531	21
22	V	24 SEMINARS		YAM MANAGEMENT, LLC	100.00%	257		257	22
23	V	25 AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	860		860	23
24	V	26 INSURANCE		YAM MANAGEMENT, LLC	100.00%	1,276		1,276	24
25	V	27 EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	13,641		13,641	25
26	V	30 DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	1,079		1,079	26
27	V	32 INTEREST		YAM MANAGEMENT, LLC	100.00%	1,375		1,375	27
28	V	33 REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%				28
29	V	34 RENT		YAM MANAGEMENT, LLC	100.00%	11,351		11,351	29
30	V	35 AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	1,295		1,295	30
31	V	35 EQUIPMENT RENTAL		YAM MANAGEMENT, LLC	100.00%	197		197	31
32	V	0		YAM MANAGEMENT, LLC	100.00%				32
33	V								33
34	V								34
35	V	19 BOOKKEEPING FEES	86,224	YAM MANAGEMENT, LLC	100.00%			(86,224)	35
36	V	19 ACCOUNTING	36,273	YAM MANAGEMENT, LLC	100.00%			(36,273)	36
37	V	34 RENT	12,000	YAM MANAGEMENT, LLC	100.00%			(12,000)	37
38	V								38
39	Total		\$ 134,497			\$ 106,695	\$ *	(27,802)	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	1		DIETARY			
			\$	YAM CONSULTING, LLC	100.00%	\$ 7,123	\$ 7,123
16	V	7		EMP. BEN. GEN. SERV.			
				YAM CONSULTING, LLC	100.00%	1,209	1,209
17	V	10		NURSING SALARY			
				YAM CONSULTING, LLC	100.00%	33,943	33,943
18	V	14		PROGRAM TRANSPORTATION			
				YAM CONSULTING, LLC	100.00%	1,485	1,485
19	V	15		EMP. BEN. HEALTHCARE			
				YAM CONSULTING, LLC	100.00%	4,494	4,494
20	V	17		ADMINISTRATIVE			
				YAM CONSULTING, LLC	100.00%	18,321	18,321
21	V	19		PROFESSIONAL FEES			
				YAM CONSULTING, LLC	100.00%	306	306
22	V	20		FEES, SUBSCRIPTIONS			
				YAM CONSULTING, LLC	100.00%	67	67
23	V	21		CLERICAL & GENERAL			
				YAM CONSULTING, LLC	100.00%	5,643	5,643
24	V	24		SEMINARS			
				YAM CONSULTING, LLC	100.00%	903	903
25	V	25		AUTO AND TRAVEL			
				YAM CONSULTING, LLC	100.00%	414	414
26	V	27		EMP. BEN.-GEN. ADMIN.			
				YAM CONSULTING, LLC	100.00%	4,044	4,044
27	V	30		DEPRECIATION			
				YAM CONSULTING, LLC	100.00%		
28	V	35		AUTO RENTAL			
				YAM CONSULTING, LLC	100.00%	2,194	2,194
29	V	6		REPAIRS AND MAINTENANCE SALARY			
				YAM CONSULTING, LLC	100.00%	1,665	1,665
30	V						
31	V						
32	V	0					
33	V	1	21,560	DIETICIAN CONSULTING	100.00%		(21,560)
34	V	10	44,550	NURSE CONSULTING	100.00%		(44,550)
35	V	17	43,500	DIR. OF OPERATIONS CONSULT	100.00%		(43,500)
36	V	19	19,064	DATA PROCESSING FEES	100.00%		(19,064)
37	V	43	6,000	MARKETING	100.00%		(6,000)
38	V						
39	Total		\$ 134,674			\$ 81,811	\$ * (52,863)

* 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%	\$ 117	\$	117	15
16	V	20 DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		35		35	16
17	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC					17
18	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC		2,813		2,813	18
19	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC		2,791		2,791	19
20	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		3,158		3,158	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34 RENT	11,351	8131 N. MONTICELLO, LLC				(11,351)	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		\$ 11,351			\$ 8,914	\$ *	(2,437)	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	39 Therapy Services	\$ 700,669	Renewal Rehab	100.00%	\$ 672,642	\$ (28,027)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 700,669			\$ 672,642	\$ * (28,027)

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

Highland Park Nursing & Rehab

0048330

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	HIGHLAND PARK NRC REALTY	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 ROSENBLUM	2.500%	EVANSTON NURSING & REHAB CENTER, LLC	EVANSTON	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDIN	4
5	DAVID KLEINER	3.750%	EXCEPTIONAL CARE, LLC	BURBANK	RENEWAL REHAB	SKOKIE	THERAPY CO.	5
6	DENNIS RUBEN	3.500%	FAIRVIEW CARE CENTER OF JOLIET,LLC	JOLIET				6
7	GARY BIDER	3.750%	INTERNATIONAL NURSING & REHAB CENTER,LLC	CHICAGO				7
8	JOYCE RUBEN	3.500%						8
9	LAURA RUBEN	1.500%	LITCHFIELD CARE CENTER,LLC	LITCHFIELD				9
10	MARLEE ASSOCIATES, LLC	4.250%	NORTH CHURCH NURSING & REHAB,LLC	JACKSONVILLE				10
11	MICHAEL ROSEN	2.000%	PLAZA NURSING AND REHAB CENTER,LLC	MIDLOTHIAN				11
12	MOSHE EPSTEIN	0.750%	PLUM GROVE NURSING AND REHAB,LLC	PALATINE				12
13	RACHEL ESFORMES	4.750%	RIVIERA CARE CENTER,LLC	CHICAGO HEIGHTS				13
14	REBECCA LAFER	3.000%	ROCKFORD NUR. & REHAB	ROCKFORD				14
15	SERENA ESFORMES	2.500%	SPRINGFIELD CARE CENTER,LLC	SPRINGFIELD				15
16	YOSEF MEYSEL	40.250%	THE ARBORS AT MICHIGAN CITY	MICHIGAN CITY, IN				16
17	ZACHARY RUBEN	1.500%	THE COPPERAS HOLLOW	CALDWELL, TX				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

Highland Park Nursing & Rehab

0048330

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Highland Park Nursing & Rehab # 0048330 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	Owner	Administrative	40.25%	See Attached	2.2	5.50%	Mgmt. Fees	\$ 6,000	17-03	1
2	Jay Meystel	Relative	Administrative	0%	See Attached	1.1	2.75%	Alloc. Salary	3,324	17-07	2
3	Joel Meystel	Relative	Administrative	0%	See Attached	1.1	5.50%	Alloc. Salary	1,250	17-07	3
4	Cynthia Meystel	Relative	Administrative	0%	See Attached	0.2	6.06%	Alloc. Salary	250	17-07	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										9
10	only amounts anticipated to be considered allowable by the Il. Dept of HFS.										10
11											11
12											12
13								TOTAL	\$ 10,824		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 Highland Park Nursing & Rehab

0048330

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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Highland Park Nursing & Rehab

0048330

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	\$ 38,064	\$ 734	1	
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	697,482	17	25,882	8,567	38,064	1,412	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	697,482	17	1,974		38,064	108	3
4	17	ADMINISTRATIVE	AVAIL. BED DAYS	697,482	17	361,644	361,644	38,064	19,736	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	697,482	17	22,257		38,064	1,215	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	697,482	17	11,509		38,064	628	6
7	21	CLERICAL & GENERAL	AVAIL. BED DAYS	697,482	17	944,249	887,220	38,064	51,531	7
8	24	SEMINARS	AVAIL. BED DAYS	697,482	17	4,715		38,064	257	8
9	25	AUTO AND TRAVEL	AVAIL. BED DAYS	697,482	17	15,759		38,064	860	9
10	26	INSURANCE	AVAIL. BED DAYS	697,482	17	23,390		38,064	1,276	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	697,482	17	249,963		38,064	13,641	11
12	30	DEPRECIATION	AVAIL. BED DAYS	697,482	17	19,767		38,064	1,079	12
13	32	INTEREST	AVAIL. BED DAYS	697,482	17	25,195		38,064	1,375	13
14	33	REAL ESTATE TAX	AVAIL. BED DAYS	697,482	17	-		38,064		14
15	34	RENT	AVAIL. BED DAYS	697,482	17	208,000		38,064	11,351	15
16	35	AUTO RENTAL	AVAIL. BED DAYS	697,482	17	23,725		38,064	1,295	16
17	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	697,482	17	3,615		38,064	197	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,955,095	\$ 1,257,431	\$ 106,695		25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Highland Park Nursing & Rehab

0048330

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	38,064	\$ 7,123	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	697,482	17	22,148		38,064	1,209	2
3	10	NURSING SALARY	AVAIL. BED DAYS	697,482	17	621,969	621,969	38,064	33,943	3
4	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	697,482	17	27,214		38,064	1,485	4
5	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	697,482	17	82,340		38,064	4,494	5
6	17	ADMINISTRATIVE	AVAIL. BED DAYS	697,482	17	335,714	335,714	38,064	18,321	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	697,482	17	5,608		38,064	306	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	697,482	17	1,231		38,064	67	8
9	21	CLERICAL & GENERAL	AVAIL. BED DAYS	697,482	17	103,402	93,384	38,064	5,643	9
10	24	SEMINARS	AVAIL. BED DAYS	697,482	17	16,540		38,064	903	10
11	25	AUTO AND TRAVEL	AVAIL. BED DAYS	697,482	17	7,585		38,064	414	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	697,482	17	74,111		38,064	4,044	12
13	30	DEPRECIATION	AVAIL. BED DAYS	697,482	17	-		38,064		13
14	35	AUTO RENTAL	AVAIL. BED DAYS	697,482	17	40,201		38,064	2,194	14
15	6	REPAIRS AND MAINTENANCE	AVAIL. BED DAYS	697,482	17	30,518		38,064	1,665	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		\$ 81,811	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Highland Park Nursing & Rehab

0048330

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

1	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	\$ 20,496	\$ 117	1
2	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	697,482	17	645	20,496	35	2
3	21	OFFICE EXPENSE	AVAIL. BED DAYS	697,482	17	-	20,496		3
4	30	DEPRECIATION	AVAIL. BED DAYS	697,482	17	51,541	20,496	2,813	4
5	32	INTEREST EXPENSE	AVAIL. BED DAYS	697,482	17	51,147	20,496	2,791	5
6	33	REAL ESTATE TAXES	AVAIL. BED DAYS	697,482	17	57,872	20,496	3,158	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	\$	\$ 8,914	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Highland Park Nursing & Rehab

0048330

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

Renewal Rehab

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	39	Therapy Services	Direct		\$	\$		\$ 672,642	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				\$	\$		\$ 672,642	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Highland Park Nursing & Rehab

0048330

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 Highland Park Nursing & Rehab

0048330

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 Highland Park Nursing & Rehab

0048330

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 Highland Park Nursing & Rehab

0048330 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 Highland Park Nursing & Rehab

0048330

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

Highland Park Nursing & Rehab

0048330

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												
												Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
													YES	NO				Original	Balance			
	A. Directly Facility Related																					
	Long-Term																					
1	Lake Forest Bank & Trust		X	Loan Payable			\$	\$ 9,280,000			\$ 653,016	1										
2	Lake Forest Bank & Trust		X	Mortgage				1,084,474			212,256	2										
3												3										
4												4										
5	See Supplemental Schedule											5										
	Working Capital																					
6	Lake Forest Bank & Trust		X	Line of Credit				1,220,350			60,617	6										
7												7										
8	See Supplemental Schedule											8										
9	TOTAL Facility Related						\$	\$ 11,584,824			\$ 925,889	9										
	B. Non-Facility Related*																					
10	Interest Income		X								343	10										
11	Insurance Interest		X								1,423	11										
12	Interest Income - Bldg co.		X								(116)	12										
13	See Supplemental Schedule										4,166	13										
14	TOTAL Non-Facility Related						\$	\$			\$ 5,816	14										
15	TOTALS (line 9+line14)						\$	\$ 11,584,824			\$ 931,705	15										

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Highland Park Nursing & Rehab

0048330

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											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	TOTAL Long-Term										7									
Working Capital																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	TOTAL Working Capital										14									
B. Non-Facility Related*																				
15	Allocated 8131 N. Monticello	X								2,791	15									
16	Allocated YAM Mgmt	X								1,375	16									
17											17									
18											18									
19											19									
20	TOTAL Non-Facility Related										4,166	20								

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.		\$	48,000		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	58,590		2
3. Under or (over) accrual (line 2 minus line 1).		\$	10,590		3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	55,432		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	66,022		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2007	45,964		8	
	2008	48,603		9	
	2009	47,529		10	
	2010	49,195		11	
	2011	55,432		12	
2012 Accrual = 2011 Accrual + 7,432					
Allocation from 8131 N. Monticello: \$3,158					
FOR BHF USE ONLY					
	13	FROM R. E. TAX STATEMENT FOR 2011	\$		13
	14	PLUS APPEAL COST FROM LINE 5	\$		14
	15	LESS REFUND FROM LINE 6	\$		15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Highland Park Nursing & Rehab COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0048330

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>16-15-427-002</u>	<u>Long Term Care Property</u>	\$ <u>55,431.63</u>	\$ <u>55,431.63</u>
2.	<u>10-23-325-045-0000</u>	<u>Home Office Allocation</u>	\$ <u>66,065.10</u>	\$ <u>3,158.28</u>
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u><u>121,496.73</u></u>	\$ <u><u>58,589.91</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 Highland Park Nursing & Rehab

0048330

Report Period Beginning:

01/01/12

Ending:

12/31/12

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,802 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2006</u>	<u>\$ 627,000</u>	<u>1</u>
2	<u>Allocated 8131 N. Monticello</u>			<u>4,857</u>	<u>2</u>
3	TOTALS			\$ 631,857	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Highland Park Nursing & Rehab

0048330

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	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	104	2007	1961	\$ 3,407,107	\$ 891,040	35	\$ 97,346	\$ (793,694)	\$ 589,620
5									
6									
7									
8									
Improvement Type**									
9	Various	2007		104,937		20	10,379	10,379	56,692
10	Various	2008		26,276		20	4,567	4,567	21,420
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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		9,501,814			475,091	475,091	1,001,348	67
68		57,499	3,414		2,029	(1,385)	4,969	68
69			150,768			(150,768)		69
70		\$ 13,097,634	\$ 1,045,222		\$ 589,412	\$ (455,810)	\$ 1,674,049	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Highland Park Nursing & Rehab

0048330

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	Totals from Page 12A, Carried Forward		\$ 13,097,634	\$ 1,045,222		\$ 589,412	\$ (455,810)	\$ 1,674,049	1
2	<u>Fox Valley Fire & Safety Building Improvements</u>	2009			20				2
3	<u>Security System - Usa Satellite</u>	2009	5,198		20	1,040	1,040	3,465	3
4	<u>Keypad, Intercom Moved/Installed In New Location</u>	2009			20				4
5	<u>Install New Water Heater</u>	2009	7,950		20	795	795	2,451	5
6	<u>Installed New Bracket Wheels Bearing And Shaft, Install/Rewire N</u>	2009	2,590		20	259	259	798	6
7	<u>Econocare - Vct, Cove Base, Handrail, Painting</u>	2009	6,547		20	327	327	1,091	7
8	<u>Annunciator - East Entrance</u>	2010	2,505		20	251	251	731	8
9	<u>Innovative Process - Two Lite Slider</u>	2010	8,368		20	837	837	2,301	9
10	<u>Usa Cable And Satelite</u>	2010	12,500		20	2,500	2,500	6,458	10
11	<u>Usa Satellite - Fire Alarm, Nurse Call, Phone, Door Systems</u>	2010	35,000		20	7,000	7,000	17,500	11
12	<u>Dgtell - Nortel Key Service, Analog Station Module, Inv#1763</u>	2010	9,124		20	912	912	2,205	12
13	<u>Keypad Entry</u>	2010	3,342		20	334	334	808	13
14	<u>Architectural Design (Sas #1512)</u>	2010			20				14
15	<u>Architectural (Sas#1560)</u>	2010	3,286		20	329	329	739	15
16	<u>Architectural Svcs (Sas#1510)</u>	2010	4,050		20	405	405	945	16
17	<u>3 Rooms To Nurse Call System</u>	2010	3,025		20	605	605	1,361	17
18	<u>Install 162 Nurse Call Stations</u>	2010	8,395		20	1,679	1,679	4,198	18
19	<u>Duro-Last Roofing System</u>	2010	13,478		20	1,348	1,348	2,920	19
20	<u>Architectural Svcs (Sas #1673)</u>	2010			20				20
21	<u>4 Bathrooms - Wall, Floor Tiles, Fixtures, Plumbing, Electrical</u>	2010	18,000		20	1,800	1,800	3,750	21
22	<u>Fire Alarm System (Convergent Contract)</u>	2010	10,000		20	1,000	1,000	2,250	22
23	<u>Laundry Exhaust Pipe</u>	2010	4,600		20	920	920	1,917	23
24	<u>Fire Alarm System (Convergent Contract)</u>	2010	46,320		20	2,316	2,316	5,211	24
25	<u>Pegasus - Custom Cabinets Built Into Wall</u>	2010	25,200		20	1,260	1,260	2,625	25
26	<u>Nurse Call System (Convergent Contract)</u>	2010	51,400		20	2,570	2,570	5,783	26
27	<u>Architectural Svcs (Sas#1697)</u>	2011			20				27
28	<u>Architectural Svcs (Sas#1828)</u>	2011			20				28
29	<u>Architectural Svcs (Sas#1746)</u>	2011			20				29
30	<u>Door Wiring/Releases</u>	2011			20				30
31	<u>Duro-Last Roofing System</u>	2011			20				31
32	<u>Custom Cabinets, 36 Bed Units</u>	2011			20				32
33	<u>Walk-In Combo Cooler/Freezer Installed In Basement Dining Roo</u>	2011			20				33
34	TOTAL (lines 1 thru 33)		\$ 13,378,511	\$ 1,045,222		\$ 617,898	\$ (427,324)	\$ 1,743,556	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Highland Park Nursing & Rehab# 0048330

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	Totals from Page 12B, Carried Forward		\$ 13,378,511	\$ 1,045,222		\$ 617,898	\$ (427,324)	\$ 1,743,556	1
2	Stationary Entrance Awning	2011			20				2
3	Tee Jay - Powering Door Hardware	2011			20				3
4	Landmark Construction - Low Voltage Systems	2011			20				4
5	Convergint Contract - Complete 30K Fire Alarm System	2011			20				5
6	Convergint Contract	2011			20				6
7	Landmark - Cap Beauty Parlor Air Duct, Rebalance System	2011			20				7
8	Convergint	2011			20				8
9	Install Keypad And Exit Buttons West Side Stairs	2011			20				9
10	Convergint	2011			20				10
11	1841.27-781.40 Reduction Of Invoice Sas Construction Admin	2011			20				11
12	Sas Construction Admin	2011			20				12
13	Sas - Construction Admin	2011			20				13
14	Landmark - Connect/Test 3 Motorized Fire/Smoke Dampers, Exte	2011			20				14
15	Convergint	2011			20				15
16	Evanston Awning	2011			20				16
17	Remodel Resident Bathrooms	2011			20				17
18	Catch Basin In Planting Bed/Weed Barrier Fabric And River Roc	2011			20				18
19	Install Door Releases, Wires For Power Door Supply	2011			20				19
20	Convergint \$5K Payment As Apart Of Us Satellite/Nuline Fire Al	2011			20				20
21	Sas Architects 2033 - June Constr.Adm.	2011			20				21
22	Sas Architects 2117 - Aug Constr.Adm.	2011			20				22
23	Added Hsws To Elevator Pit, Fire Caulk Penetrations	2011			20				23
24	Econocare	2011			20				24
25	Econocare \$25,000	2011			20				25
26	Econocare	2011			20				26
27	Econocare	2011			20				27
28	Econocare Contract Work (50K+22,775.25+39171.69 Of \$50K Pm	2011			20				28
29	Econocare (Part Of 50K Pmt Pertains To Other Invoices)	2011			20				29
30	Convergint Technologies Contract (Remaining Balance Pmt)	2011			20				30
31	Keypad Installation For Ambulance Door (Advantage)	2011			20				31
32	Keypad Transceiver (Hme)	2011			20				32
33	Remove/Replace Curb/Gutter Ambulance Bay (Landmark)	2011			20				33
34	TOTAL (lines 1 thru 33)		\$ 13,378,511	\$ 1,045,222		\$ 617,898	\$ (427,324)	\$ 1,743,556	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	Totals from Page 12C, Carried Forward		\$ 13,378,511	\$ 1,045,222		\$ 617,898	\$ (427,324)	\$ 1,743,556	1
2	Install Elevator Keypad (On-Line Communications)	2011			20				2
3	Walk-In Combo Freezer/Cooler Installed In Basement Dining Room	2011	26,500		20	1,325	1,325	2,429	3
4	Custom Cabinets Built In And Secured To Wall	2011	25,200		20	1,260	1,260	2,415	4
5	Duro-Last Roofing System	2011	27,577		20	1,379	1,379	2,528	5
6	Low Voltage Systems	2011	99,000		20	4,950	4,950	9,075	6
7	Architects	2011	3,598		20	180	180	330	7
8	Bathroom Fixtures, Flooring, Lighting	2011	18,800		20	940	940	1,332	8
9	Storm Sewer System Updates	2011	9,000		20	450	450	675	9
10	Remove Curb & Gutters	2011	3,700		20	185	185	216	10
11	Counter, Wallcovering	2012	4,356		20	399	399	399	11
12	Landscaping	2012	5,200		20	173	173	173	12
13	Dining Room Repairs	2012	4,501		20	300	300	300	13
14	Mechanical Screens	2012	8,500		20	1,700	1,700	1,700	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)		\$ 13,614,443	\$ 1,045,222		\$ 631,139	\$ (414,083)	\$ 1,765,128	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Highland Park Nursing & Rehab

0048330

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	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		\$ 13,614,443	\$ 1,045,222		\$ 631,139	\$ (414,083)	\$ 1,765,128	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		\$ 13,614,443	\$ 1,045,222		\$ 631,139	\$ (414,083)	\$ 1,765,128	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Highland Park Nursing & Rehab

0048330

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	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Chandalier, Wallcovering, Flooring, Tile, Handrails	2010	190,983		20	9,549	9,549	28,647	9
10	Walls, Repair Cracks, Floor Prep	2010	5,634		20	282	282	845	10
11	Flooring, Chandalier, Cove Base	2010	90,707		20	4,535	4,535	13,606	11
12	Blinds, Ramp, Flooring, Cornice, Painting	2010	113,000		20	5,650	5,650	16,950	12
13	VCT & Cove Base, Flooring, Cabinetry, Painting	2010	270,481		20	13,524	13,524	40,572	13
14	Elevator Floor, Granite Wall Caps, Floor Prep, Window Treatment	2010	20,443		20	1,022	1,022	3,066	14
15	Porcelain Tile, Wallcovering, Custom Reception Desk	2010	18,851		20	943	943	2,828	15
16	Sink Cabinet, Flooring	2010	7,862		20	393	393	1,179	16
17	Flooring, Wallcovering, Cove Base, Handrails, Room Signage	2010	101,919		20	5,096	5,096	15,288	17
18	Handrails, VCT, Flooring, Cubicle Tracks/Curtains, Painting	2010	203,450		20	10,173	10,173	30,518	18
19	Vinyl Cove Base, Corner Guards	2011	1,850		20	92	92	185	19
20	Corner Guards, VCT, Flooring, Signage	2011	44,933		20	2,247	2,247	4,493	20
21	Flooring, Bathroom Mirrors, Window Treatments, Cubicle Track	2011	53,302		20	2,665	2,665	5,330	21
22	Wall Sconces	2011	2,391		20	120	120	239	22
23	Additional Construction Costs	2011	81,620		20	4,081	4,081	8,162	23
24	General Construction on Building	2011	7,849,388		20	392,469	392,469	784,939	24
25	SAS Architect Fees	2011	445,000		20	22,250	22,250	44,500	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Highland Park Nursing & Rehab

0048330

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	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)	\$ 9,501,814	\$		\$ 475,091	\$ 475,091	\$ 1,001,348	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	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated 8131 N. Monticello	2010	37,739	1,122		968	(154)	2,379	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated 8131 N. Monticello	2010	16,905	1,691		845	(846)	2,145	9
10									10
11	Allocated YAM Mangement	2010	1,798	46		180	134	409	11
12	Allocated YAM Mangement	2012	1,057	555		36	(519)	36	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Highland Park Nursing & Rehab

0048330

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	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)		\$ 57,499	\$ 3,414		\$ 2,029	\$ (1,385)	\$ 4,969	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	\$ 485,993	\$ 13	\$ 56,750	\$ 56,737	10	\$ 200,167	71
72	Current Year Purchases	29,981	444	4,908	4,464	10	4,908	72
73	Fully Depreciated Assets	11,354				10	11,354	73
74								74
75	TOTALS	\$ 527,328	\$ 457	\$ 61,659	\$ 61,202		\$ 216,429	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		2009 GMC Savana	2009	\$ 46,762	\$	\$ 7,671	\$ 7,671	5	\$ 32,379	76
77		YAM Management	2010	1,856	20	482	462	5	537	77
78										78
79										79
80	TOTALS			\$ 48,618	\$ 20	\$ 8,153	\$ 8,133		\$ 32,916	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)	\$ 14,822,245	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,045,699	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 700,951	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (344,748)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,014,473	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: \$ 7,852 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	Auto Lease		\$ _____	\$ _____	17
18	Allocated from YAM Management			1,295	18
19	Allocated from YAM Consulting			2,194	19
20					20
21	TOTAL		\$ _____	\$ 3,489	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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		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	\$		\$	270,000	\$			\$	270,000	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				39,803					39,803	2
3	Licensed Recreational Therapist		hrs										3
4	Licensed Physical Therapist	39 - 03	hrs				375,399					375,399	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						289,233			289,233	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>						3,755		9,055			12,810	13
14	TOTAL			\$			688,957	\$	298,288			987,245	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 **Highland Park Nursing & Rehab**# **0048330**Report Period Beginning: **01/01/12**

Ending:

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*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,916	\$ 29,497	1
2	Cash-Patient Deposits	(429)	(429)	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,074,724	2,074,724	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	90,076	90,076	6
7	Other Prepaid Expenses	468	468	7
8	Accounts Receivable (owners or related parties)	251,564	251,564	8
9	Other(specify): See Attached Schedule	77,928	688,263	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,496,247	\$ 3,134,163	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		627,000	13
14	Buildings, at Historical Cost		3,407,107	14
15	Leasehold Improvements, at Historical Cost	752,931	9,051,425	15
16	Equipment, at Historical Cost	437,351	2,485,974	16
17	Accumulated Depreciation (book methods)	(414,255)	(2,142,083)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	12,000	37,262	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 788,027	\$ 13,466,685	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,284,274	\$ 16,600,848	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 921,866	\$ 921,865	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,220,350	1,220,350	29
30	Accrued Salaries Payable	245,848	245,848	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,853	11,853	31
32	Accrued Real Estate Taxes(Sch.IX-B)	55,432	55,432	32
33	Accrued Interest Payable	5,780	77,279	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached Schedule		2,442,009	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,461,129	\$ 4,974,636	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		10,364,474	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 10,364,474	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,461,129	\$ 15,339,110	46
47	TOTAL EQUITY(page 18, line 24)	\$ 823,145	\$ 1,261,738	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,284,274	\$ 16,600,848	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 402,645	1
2	Restatements (describe):		2
3	Rounding	6	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 402,651	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	382,579	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	87,500	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(49,585)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 420,494	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 823,145	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Highland Park Nursing & Rehab

0048330

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,449,443	1
2	Discounts and Allowances for all Levels	(2,096,786)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,352,657	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,044,365	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,044,365	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	270,295	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	25,428	19
20	Radiology and X-Ray	4,135	20
21	Other Medical Services	10,530	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 310,388	23
D. Non-Operating Revenue			
24	Contributions	500	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 500	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,683	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,683	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,709,593	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,022,198	31
32	Health Care	2,222,071	32
33	General Administration	1,256,871	33
B. Capital Expense			
34	Ownership	1,265,670	34
C. Ancillary Expense			
35	Special Cost Centers	1,221,448	35
36	Provider Participation Fee	338,756	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,327,014	40
41	Income before Income Taxes (line 30 minus line 40)**	382,579	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 382,579	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,767,698	44
45	Private Pay - Net Inpatient Revenue	1,424,627	45
46	Medicare - Net Inpatient Revenue	931,535	46
47	Other-(specify) <u>Insurance</u>	227,187	47
48	Other-(specify) <u>Veterans</u>	1,610	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,352,657	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 Highland Park Nursing & Rehab

0048330

Report Period Beginning:

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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	2,077	2,244	\$ 98,951	\$ 44.10	1
2	Assistant Director of Nursing	853	885	26,963	30.47	2
3	Registered Nurses	17,414	18,620	567,524	30.48	3
4	Licensed Practical Nurses	11,912	12,987	322,327	24.82	4
5	CNAs & Orderlies	53,184	57,325	717,131	12.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	197	215	2,638	12.27	8
9	Activity Director	2,102	2,278	44,800	19.67	9
10	Activity Assistants	3,834	4,009	41,017	10.23	10
11	Social Service Workers	2,513	2,602	39,037	15.00	11
12	Dietician					12
13	Food Service Supervisor	2,033	2,091	53,291	25.49	13
14	Head Cook	3,867	4,313	56,971	13.21	14
15	Cook Helpers/Assistants	12,088	13,424	127,798	9.52	15
16	Dishwashers					16
17	Maintenance Workers	2,107	2,441	48,375	19.82	17
18	Housekeepers	11,796	12,905	135,761	10.52	18
19	Laundry	5,673	6,418	68,611	10.69	19
20	Administrator	2,477	2,539	94,052	37.04	20
21	Assistant Administrator	648	664	15,961	24.04	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,667	8,113	92,243	11.37	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	2,403	2,576	43,044	16.71	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,976	4,240	125,692	29.64	33
34	TOTAL (lines 1 - 33)	148,821	160,889	\$ 2,722,187 *	\$ 16.92	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	431	\$ 23,704	01-03	35
36	Medical Director	Monthly	60,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	594	44,550	10-03	38
39	Pharmacist Consultant	Monthly	4,576	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	Monthly	2,200	11-03	44
45	Social Service Consultant	50	3,064	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,075	\$ 138,094		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	
Etan Bleichamn	Administrator	0	\$ 45,145	Workers' Compensation Insurance	\$ 84,947	IDPH License Fee	\$	
Heather Levine	Administrator	0	48,907	Unemployment Compensation Insurance	30,287	Advertising: Employee Recruitment	12,520	
Nosson Factor	Asst Admin	0	15,961	FICA Taxes	203,279	Health Care Worker Background Check		
				Employee Health Insurance	100,570	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	206 2,952	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Permits	2,079	
				Pension Expense	22,635	Dues & Subscriptions	17,176	
				Other Employee Benefits	3,940	Allocated From 8131 N. Monticello	35	
						Allocated From YAM Consulting	67	
						See Supplemental Schedule	628	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 110,013					
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 445,658	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 35,457	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
YAM Administrative Consultant			\$ 43,500				Out-of-State Travel	\$
Management Fees - Yosef Meystel			6,000					
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 49,500					
							Seminar Expense	767
C. Professional Services							Allocated From YAM Consulting	903
Vendor/Payee	Type		Amount				Allocated From YAM Management	257
Frost, Ruttenberg & Rothblatt	Accounting		\$ 15,000					
YAM Management	Accounting		36,273				Entertainment Expense	()
YAM Management	Bookkeeping		86,224				(agree to Sch. V, line 24, col. 8)	
YAM Consulting	Data Processing		19,064				TOTAL	\$ 1,927
Medifax-EDI, LLC	Data Processing		5,285					
Health Data Systems	Data Processing		3,243					
DGTell	Data Processing		360					
American Data	Data Processing		6,661					
Galaxy Hosted Software	Data Processing		16,838					
System Design, Inc.	Data Processing		38					
HD Supply	Data Processing		285					
See Supplemental Schedule			34,064					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 223,335	TOTAL		\$		

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

(See instructions.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Highland Park Nursing & Rehab

0048330

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. ICLTC: \$7,088
- (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. \$ 30,226 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 338,756
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT