

		FOR BHF USE					

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0050187

Facility Name: International Nursing And Rehab Center

Address: 4815 South Western Avenue Chicago 60609
Number City Zip Code

County: Cook

Telephone Number: (773) 927- 4200 Fax # (773) 927-1287

HFS ID Number:

Date of Initial License for Current Owners: 10/01/08

Type of Ownership:

☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL
☐ Charitable Corp.	☐ Individual	☐ State
☐ Trust	☐ Partnership	☐ County
IRS Exemption Code	☐ Corporation	☐ Other
	☐ "Sub-S" Corp.	
	☒ Limited Liability Co.	
	☐ Trust	
	☐ Other	

In the event there are further questions about this report, please contact:
Name: Steve Lavenda Telephone Number: (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider	(Signed)		(Date)	
	(Type or Print Name)			
	(Title)			
Paid Preparer	(Signed)		(Date)	
	(Print Name and Title)	Cary C. Buxbaum, C.P.A.		
	(Firm Name & Address)	Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015		
	(Telephone)	(847) 236-1111 Fax # (847) 236-1155		
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Nursing And Rehab Center

0050187 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

	1	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>218</u>	Skilled (SNF)	<u>218</u>	<u>79,570</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>218</u>	TOTALS	<u>218</u>	<u>79,570</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>34,107</u>	<u>397</u>	<u>9,639</u>	<u>44,143</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>34,107</u>	<u>397</u>	<u>9,639</u>	<u>44,143</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.48%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 10/01/2008

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 10/01/2008 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 218 and days of care provided 9,061

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: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number International Nursing And Rehab Center # 0050187 Report Period Beginning: 01/01/11 Ending: 12/31/11
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 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	264,206	23,957	25,510	313,673		313,673	(10,139)	303,534			1
2	Food Purchase		218,406		218,406	(24,145)	194,261	(20)	194,242			2
3	Housekeeping	214,218	38,934		253,152		253,152		253,152			3
4	Laundry	79,029	21,289		100,318		100,318		100,318			4
5	Heat and Other Utilities			265,476	265,476		265,476	1,761	267,237			5
6	Maintenance	52,240		118,083	170,323		170,323	11,831	182,154			6
7	Other (specify):*							2,054	2,054			7
8	TOTAL General Services	609,693	302,586	409,069	1,321,348	(24,145)	1,297,203	5,487	1,302,691			8
	B. Health Care and Programs											
9	Medical Director			26,531	26,531		26,531		26,531			9
10	Nursing and Medical Records	2,346,827	182,207	97,820	2,626,854		2,626,854	(19,871)	2,606,983			10
10a	Therapy	110,966	688		111,654		111,654		111,654			10a
11	Activities	142,086	13,951	2,195	158,232		158,232		158,232			11
12	Social Services	47,354		5,511	52,865		52,865		52,865			12
13	CNA Training											13
14	Program Transportation			8,321	8,321		8,321	4,440	12,761			14
15	Other (specify):*							8,619	8,619			15
16	TOTAL Health Care and Programs	2,647,233	196,846	140,378	2,984,457		2,984,457	(6,812)	2,977,645			16
	C. General Administration											
17	Administrative	173,798		56,500	230,298		230,298	61,533	291,831			17
18	Directors Fees											18
19	Professional Services			321,941	321,941	(185)	321,756	(183,423)	138,333			19
20	Dues, Fees, Subscriptions & Promotions			70,002	70,002		70,002	(41,179)	28,823			20
21	Clerical & General Office Expenses	158,316	3,008	365,398	526,722		526,722	(197,958)	328,764			21
22	Employee Benefits & Payroll Taxes			695,457	695,457	24,145	719,602		719,602			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,306	1,306		1,306	1,623	2,929			24
25	Other Admin. Staff Transportation			1,246	1,246		1,246	4,057	5,303			25
26	Insurance-Prop.Liab.Malpractice			320,170	320,170		320,170	2,450	322,620			26
27	Other (specify):*							30,865	30,865			27
28	TOTAL General Administration	332,114	3,008	1,832,020	2,167,142	23,960	2,191,102	(322,032)	1,869,070			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,589,040	502,440	2,381,467	6,472,947	(185)	6,472,762	(323,356)	6,149,406			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			41,624	41,624		41,624	(3,044)	38,580			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			68,840	68,840		68,840	6,266	75,106			32
33	Real Estate Taxes			312,823	312,823	185	313,008	3,366	316,374			33
34	Rent-Facility & Grounds			1,466,153	1,466,153		1,466,153	(14,000)	1,452,153			34
35	Rent-Equipment & Vehicles			5,819	5,819		5,819	10,011	15,830			35
36	Other (specify):*											36
37	TOTAL Ownership			1,895,259	1,895,259	185	1,895,444	2,599	1,898,043			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		402,415	1,023,562	1,425,977		1,425,977		1,425,977			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			119,355	119,355		119,355		119,355			42
43	Other (specify):*			422,580	422,580		422,580	(422,580)				43
44	TOTAL Special Cost Centers		402,415	1,565,497	1,967,912		1,967,912	(422,580)	1,545,332			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,589,040	904,855	5,842,223	10,336,118		10,336,118	(743,337)	9,592,781			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(10,971)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(11,017)	30		9
10	Interest and Other Investment Income	(234)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(20)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(540)	21		18
19	Entertainment	(7,204)	21		19
20	Contributions	(14,950)	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	(285,246)	21		24
25	Fund Raising, Advertising and Promotional	(26,289)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(421,304)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (777,774)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	34,437		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 34,437		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (743,337)		37

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

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

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

Report Period Beginning: Ending:

ID# 005018701/01/1112/31/11

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Miscellaneous Income	\$ (2,798)	21	1
2	Vending Income	(10)	21	2
3	Other Marketing Expense	(8,000)	43	3
4	Bank Charges	(17,880)	21	4
5	Secretary of State - Annual Report	(870)	20	5
6	Additional R&M	19,808	06	6
7	Non-Allowable Legal	(5,554)	19	7
8	Non-Allowable Expense	(406,000)	43	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
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	(421,304)		49

STATE OF ILLINOIS
International Nursing And Rehab Center

ID# 0050187
Report Period Beginning: 01/01/11
Ending: 12/31/11

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

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-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

X NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	YAM MANAGEMENT, LLC	100.00%	\$ 1,761	\$ 1,761	15
16	V	6	REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	2,994	2,994	16
17	V	7	EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	212	212	17
18	V	17	ADMINISTRATIVE		YAM MANAGEMENT, LLC	100.00%	41,328	41,328	18
19	V	19	PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	3,086	3,086	19
20	V	20	FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	760	760	20
21	V	21	CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	103,190	103,190	21
22	V	24	SEMINARS		YAM MANAGEMENT, LLC	100.00%	1,176	1,176	22
23	V	25	AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	3,419	3,419	23
24	V	26	INSURANCE		YAM MANAGEMENT, LLC	100.00%	2,450	2,450	24
25	V	27	EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	27,354	27,354	25
26	V	30	DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	1,924	1,924	26
27	V	32	INTEREST		YAM MANAGEMENT, LLC	100.00%	116	116	27
28	V	33	REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%	5,378	5,378	28
29	V	34	RENT		YAM MANAGEMENT, LLC	100.00%	18,073	18,073	29
30	V	35	AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	2,096	2,096	30
31	V	35	EQUIPMENT RENTAL		YAM MANAGEMENT, LLC	100.00%	741	741	31
32	V	0			YAM MANAGEMENT, LLC	100.00%			32
33	V								33
34	V								34
35	V	19	BOOKKEEPING FEES	130,352	YAM MANAGEMENT, LLC	100.00%		(130,352)	35
36	V	19	ACCOUNTING	37,250	YAM MANAGEMENT, LLC	100.00%		(37,250)	36
37	V	34	RENT	14,000	YAM MANAGEMENT, LLC	100.00%		(14,000)	37
38	V								38
39	Total			\$ 181,602			\$ 216,058	\$ * 34,456	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	\$	YAM CONSULTING, LLC	100.00%	\$ 15,371	\$	15,371 15
16	V	7	EMP. BEN. GEN. SERV.		YAM CONSULTING, LLC	100.00%	1,842		1,842 16
17	V	10	NURSING SALARY		YAM CONSULTING, LLC	100.00%	69,229		69,229 17
18	V	14	PROGRAM TRANSPORTATION		YAM CONSULTING, LLC	100.00%	4,440		4,440 18
19	V	15	EMP. BEN. HEALTHCARE		YAM CONSULTING, LLC	100.00%	8,619		8,619 19
20	V	17	ADMINISTRATIVE		YAM CONSULTING, LLC	100.00%	22,705		22,705 20
21	V	19	PROFESSIONAL FEES		YAM CONSULTING, LLC	100.00%	6,021		6,021 21
22	V	20	FEES, SUBSCRIPTIONS		YAM CONSULTING, LLC	100.00%	98		98 22
23	V	21	CLERICAL & GENERAL		YAM CONSULTING, LLC	100.00%	12,414		12,414 23
24	V	24	SEMINARS		YAM CONSULTING, LLC	100.00%	447		447 24
25	V	25	AUTO AND TRAVEL		YAM CONSULTING, LLC	100.00%	638		638 25
26	V	27	EMP. BEN.-GEN. ADMIN.		YAM CONSULTING, LLC	100.00%	3,511		3,511 26
27	V	30	DEPRECIATION		YAM CONSULTING, LLC	100.00%	78		78 27
28	V	35	AUTO RENTAL		YAM CONSULTING, LLC	100.00%	7,174		7,174 28
29	V	0							29
30	V								30
31	V								31
32	V								32
33	V	01	DIETICIAN CONSULTING	25,510	YAM CONSULTING, LLC	100.00%			(25,510) 33
34	V	10	NURSE CONSULTING	89,100	YAM CONSULTING, LLC	100.00%			(89,100) 34
35	V	17	DIR. OF OPERATIONS CONSULT	2,500	YAM CONSULTING, LLC	100.00%			(2,500) 35
36	V	19	DATA PROCESSING FEES	19,973	YAM CONSULTING, LLC	100.00%			(19,973) 36
37	V	43	MARKETING	8,580	YAM CONSULTING, LLC	100.00%			(8,580) 37
38	V								38
39	Total			\$ 145,663			\$ 152,587	\$ *	6,924 39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	\$	8131 N. MONTICELLO, LLC	100.00%	\$ 599	\$ 599	15
16	V	20	DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		72	72	16
17	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		116	116	17
18	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		5,971	5,971	18
19	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		6,384	6,384	19
20	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		3,366	3,366	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	18,073	8131 N. MONTICELLO, LLC			(18,073)	26
27	V	33	REAL ESTATE TAXES	5,378	8131 N. MONTICELLO, LLC			(5,378)	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			\$ 23,451			\$ 16,508	\$ * (6,943)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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

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.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	1.500%	BERKSHIRE NURSING & REHAB CENTER,LLC	FOREST PARK	YAM MANAGEMENT	SKOKIE	MANAGEMENT CO.	1
2	257 LIMITED PARTNERSHIP	3.000%	CONCORD NURSING AND REHABILITATION CENTER,LLC	OAK LAWN	YAM CONSULTING	SKOKIE	CONSULTING CO.	2
3	42170 LIMITED PARTNERSHIP	1.500%	DOLTON NURSING & REHAB,LLC	DOLTON	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	3
4	ATIED ASSOCIATES, LLC	31.670%	EVANSTON NURSING & REHAB CENTER, LLC	EVANSTON				4
5	CHRISTINA INOFRE	1.000%	EXCEPTIONAL CARE, LLC	BURBANK				5
6	DAVID BERKOWITZ	25.170%	FAIRVIEW CARE CENTER OF JOLIET,LLC	JOLIET				6
7	JOSHUA WEINSTEIN	1.000%	HIGHLAND PARK NURSING AND REHAB CENTER, LLC	HIGHWOOD				7
8	HENRI VENTRUES, LLC	10.000%	JACKSONVILLE CARE CENTER	JACKSONVILLE				8
9	YOSEF MEYSTEL	25.160%	LITCHFIELD CARE CENTER,LLC	LITCHFIELD				9
10			NORTH CHURCH NURSING & REHAB,LLC	JACKSONVILLE				10
11			PLAZA NURSING AND REHAB CENTER,LLC	MIDLOTHIAN				11
12			PLUM GROVE NURSING AND REHAB,LLC	PALATINE				12
13			RIVIERA CARE CENTER,LLC	CHICAGO HEIGHTS				13
14			ROCKFORD NUR. & REHAB	ROCKFORD				14
15			SPRINGFIELD CARE CENTER,LLC	SPRINGFIELD				15
16			LINCOLN REHABILITATION CENTER, LLC	DECATUR				16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number International Nursing And Rehab Center # 0050187 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

	1 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	25.16%	See Attached	4.6	11.50%	Consult. Fees	\$ 21,000	17-3	1
2	David Berkowitz	Owner	Administrative	25.17%	See Attached	4.6	11.50%	Consult. Fees	33,000	17-3	2
3	Jay Meystel	Relative	Administrative	0.00%	See Attached	2.3	5.75%	Alloc. Salary	7,009	17-7	3
4	Joel Meystel	Relative	Administrative	0.00%	See Attached	2.3	5.75%	Alloc. Salary	2,668	17-7	4
5	Joshua Weinstein	Owner	Administrative	1.00%	See Attached	4.6	11.50%	Alloc. Salary	9,066	17-7	5
6	Christina Inofre	Owner	Nursing	1.00%	See Attached	4.6	11.50%	Alloc. Salary	12,342	10-7	6
7	Meir Meystel	Relative	Administrative	0.00%	See Attached	40	100.00%	Salary	25,180	17-1	7
8	Shimmy Mestel	Relative	Administrative	0.00%	See Attached	40	100.00%	Salary	17,362	17-1	8
9											9
10	Where applicable, the amounts reported on this page have been adjusted from the actual costs to										10
11	reflect only amounts anticipated to be considered allowable by the Illinois Department of HFS.										11
12											12
13								TOTAL	\$ 127,627		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 International Nursing And Rehab Center # 0050187 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	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

Facility Name & ID Number International Nursing And Rehab Center # 0050187 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	UTILITIES	AVAIL. BED DAYS	686,836	17	\$ 15,204	\$	79,570	\$ 1,761	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	686,836	17	25,846	8,238	79,570	2,994	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	686,836	17	1,829		79,570	212	3
4	17	ADMINISTRATIVE	AVAIL. BED DAYS	686,836	17	356,736	356,736	79,570	41,328	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	26,635		79,570	3,086	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	6,564		79,570	760	6
7	21	CLERICAL & GENERAL	AVAIL. BED DAYS	686,836	17	890,719	835,933	79,570	103,190	7
8	24	SEMINARS	AVAIL. BED DAYS	686,836	17	10,148		79,570	1,176	8
9	25	AUTO AND TRAVEL	AVAIL. BED DAYS	686,836	17	29,510		79,570	3,419	9
10	26	INSURANCE	AVAIL. BED DAYS	686,836	17	21,145		79,570	2,450	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	686,836	17	236,117		79,570	27,354	11
12	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	16,611		79,570	1,924	12
13	32	INTEREST	AVAIL. BED DAYS	686,836	17	1,006		79,570	116	13
14	33	REAL ESTATE TAX	AVAIL. BED DAYS	686,836	17	46,424		79,570	5,378	14
15	34	RENT	AVAIL. BED DAYS	686,836	17	156,000		79,570	18,073	15
16	35	AUTO RENTAL	AVAIL. BED DAYS	686,836	17	18,091		79,570	2,096	16
17	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	686,836	17	6,400		79,570	741	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,864,985	\$ 1,200,907		\$ 216,058	25

VIII. ALLOCATION OF INDIRECT COSTS

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	AVAIL. BED DAYS	686,836	17	\$ 132,684	\$ 123,698	79,570	\$ 15,371	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	686,836	17	15,896		79,570	1,842	2
3	10	NURSING SALARY	AVAIL. BED DAYS	686,836	17	597,577	597,577	79,570	69,229	3
4	14	PROGRAM TRANSPORTATION	AVAIL. BED DAYS	686,836	17	38,325		79,570	4,440	4
5	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	686,836	17	74,394		79,570	8,619	5
6	17	ADMINISTRATIVE	AVAIL. BED DAYS	686,836	17	195,987	195,987	79,570	22,705	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	51,975		79,570	6,021	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	849		79,570	98	8
9	21	CLERICAL & GENERAL	AVAIL. BED DAYS	686,836	17	107,160	91,547	79,570	12,414	9
10	24	SEMINARS	AVAIL. BED DAYS	686,836	17	3,858		79,570	447	10
11	25	AUTO AND TRAVEL	AVAIL. BED DAYS	686,836	17	5,508		79,570	638	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	686,836	17	30,309		79,570	3,511	12
13	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	673		79,570	78	13
14	35	AUTO RENTAL	AVAIL. BED DAYS	686,836	17	61,921		79,570	7,174	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,317,116	\$ 1,008,809		\$ 152,587	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Nursing And Rehab Center # 0050187 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	\$ 5,168	\$	20,440	\$ 599	1
2	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	624		20,440	72	2
3	21	OFFICE EXPENSE	AVAIL. BED DAYS	686,836	17	1,000		20,440	116	3
4	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	51,542		20,440	5,971	4
5	32	INTEREST EXPENSE	AVAIL. BED DAYS	686,836	17	55,103		20,440	6,384	5
6	33	REAL ESTATE TAXES	AVAIL. BED DAYS	686,836	17	29,058		20,440	3,366	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 142,495	\$		\$ 16,508	25

Facility Name & ID Number International Nursing And Rehab Center # 0050187 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	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

Facility Name & ID Number International Nursing And Rehab Center # 0050187 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

()

()

	1	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

Facility Name & ID Number International Nursing And Rehab Center # 0050187 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	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

Facility Name & ID Number International Nursing And Rehab Center # 0050187 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	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

Facility Name & ID Number International Nursing And Rehab Center # 0050187 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

()

()

	1	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

Facility Name & ID Number International Nursing And Rehab Center # 0050187 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	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

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							\$					\$	1
2													2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	First Bank		X	Line of Credit				1,623,983				66,545	6
7	Assurance		X	Insurance Financing								2,295	7
8	See Supplemental Schedule												8
9	TOTAL Facility Related						\$	1,623,983			\$	68,841	9
	B. Non-Facility Related*												
10	Interst Income		X									(234)	10
11	YAM Management Allocation	X										116	11
12	8131 N. Monticello Allocation	X										6,384	12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$				\$	6,266	14
15	TOTALS (line 9+line14)						\$	1,623,983			\$	75,107	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.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	Assurance		X	Insurance Financing			\$					8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital											14	
	B. Non-Facility Related*												
15							\$					15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.		\$	295,000	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.)		\$	306,183	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	11,183	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	305,000	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.)		\$	185	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.		\$	316,368	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006		8	
		2007		9	
		2008	280,157	10	
		2009	290,184	11	
		2010	302,817	12	
2011 Accrual = 2010 Tax (Rounded)					
8131 N. Monticello Allocation = \$3,652					

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

International Nursing And Rehab Center

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0050187

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-1111

FAX #:

(847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u>20-07-104-001-0000</u>	<u>Long Term Care Property</u>	\$ <u>187,078.10</u>	\$ <u>187,078.10</u>
2. <u>20-07-104-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>2,530.19</u>	\$ <u>2,530.19</u>
3. <u>20-07-104-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>1,324.91</u>	\$ <u>1,324.91</u>
4. <u>20-07-104-005-0000</u>	<u>Long Term Care Property</u>	\$ <u>706.56</u>	\$ <u>706.56</u>
5. <u>20-07-104-009-0000</u>	<u>Long Term Care Property</u>	\$ <u>56,830.51</u>	\$ <u>56,830.51</u>
6. <u>20-07-104-011-0000</u>	<u>Long Term Care Property</u>	\$ <u>53,316.83</u>	\$ <u>53,316.83</u>
7. <u>20-07-104-012-0000</u>	<u>Long Term Care Property</u>	\$ <u>1,030.18</u>	\$ <u>1,030.18</u>
8. <u>Allocated from 8131 N. Monticello</u>	<u>Home Office Allocation</u>	\$ <u>35,987.49</u>	\$ <u>3,652.12</u>
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>338,804.77</u>	\$ <u>306,469.40</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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME International Nursing And Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050187

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

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

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

89,132

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

3

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	Home Office		2010	\$ 10,311	1
2					2
3	TOTALS			\$ 10,311	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

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

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

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

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	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		119,815	6,353		4,230	(2,123)	6,242	68
69	Financial Statement Depreciation			41,624			(41,624)		69
70	TOTAL (lines 4 thru 69)		\$ 119,815	\$ 47,977		\$ 4,230	\$ (43,747)	\$ 6,242	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number International Nursing And Rehab Center

0050187

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 119,815	\$ 47,977		\$ 4,230	\$ (43,747)	\$ 6,242	1
2	Plumbing Work	2009	23,882		20	2,388	2,388	6,369	2
3	Refrigeration System	2010	14,156		20	2,831	2,831	4,247	3
4	Vinyl Tile	2010	4,353		20	290	290	399	4
5	New Floor Installation	2010	13,988		20	933	933	1,049	5
6	Wanderer Monitoring System	2011	8,200		20	1,640	1,640	1,640	6
7	Sains - Flooring	2011	16,796		20	840	840	840	7
8	Seco Refrigeration - Repair Chiller	2011	5,045		20	589	589	589	8
9	New Outlets Piped To Emergency Circuit	2011	5,950		20	149	149	149	9
10	Furnish & Install Security System	2011	7,297		20	182	182	182	10
11	Healthcare Security System	2011	6,400		20	107	107	107	11
12	Sains Flooring	2011	5,875		20	98	98	98	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 231,757	\$ 47,977		\$ 14,277	\$ (33,700)	\$ 21,910	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 12B, Carried Forward		\$ 231,757	\$ 47,977		\$ 14,277	\$ (33,700)	\$ 21,910	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
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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)		\$ 231,757	\$ 47,977		\$ 14,277	\$ (33,700)	\$ 21,910	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$231,757	\$47,977		\$14,277	\$(33,700)	\$21,910	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$231,757	\$47,977		\$14,277	\$(33,700)	\$21,910	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 12D, Carried Forward		\$ 231,757	\$ 47,977		\$ 14,277	\$ (33,700)	\$ 21,910	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 231,757	\$ 47,977		\$ 14,277	\$ (33,700)	\$ 21,910	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	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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	Building Company Information Continued		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		\$	\$		\$	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 8131 N. Monticello	2010	80,113	2,382	39	2,054	(328)	2,996	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from 8131 N. Monticello	2010	35,886	3,589	20	1,794	(1,795)	2,760	9
10	Allocated from YAM Management	2010	3,816	382	20	382		486	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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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)		\$ 119,815	\$ 6,353		\$ 4,230	\$ (2,123)	\$ 6,242	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	\$78,405	\$1,263	\$18,217	\$16,954	10	\$58,620	71
72	Current Year Purchases	29,995	13	5,924	5,911	10	5,924	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$108,399	\$1,276	\$24,140	\$22,864		\$64,543	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		YAM MANAGEMENT, LLC	2009	\$3,115	\$345	\$164	\$(181)	5	\$56	76
77										77
78										78
79										79
80	TOTALS			\$3,115	\$345	\$164	\$(181)		\$56	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$353,582	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$49,598	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$38,581	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(11,017)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$86,509	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:Albany Bank and Trust Company, 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:		218		\$ 1,452,153			3
4	Additions							4
5	Allocated from YAM Management							5
6								6
7	TOTAL		218		\$ 1,452,153			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:Option to buy in 2012*

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

15. Is Movable equipment rental included in building rental?☐ YES☐ NO
16. Rental Amount for movable equipment: \$ 4,033 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 Leasing	2010 Toyota Corolla	\$ 319.00	\$ 2,528	17
18	Allocated from YAM Management			2,096	18
19	Allocated from YAM Consulting			7,174	19
20					20
21	TOTAL		\$ 319.00	\$ 11,798	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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

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

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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 452,372	\$		\$ 452,372	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			136,432			136,432	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			434,668			434,668	4
5	Physician Care	39 - 03	visits			90			90	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				364,543		364,543	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						37,872		37,872	13
14	TOTAL			\$		\$ 1,023,562	\$ 402,415		\$ 1,425,977	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

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	\$ 10,185	\$	1
2	Cash-Patient Deposits	40,413		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,180,671		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	305,037		6
7	Other Prepaid Expenses	2,100		7
8	Accounts Receivable (owners or related parties)	1,751,801		8
9	Other(specify): See Attached Schedule	637,341		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,927,548	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	93,755		15
16	Equipment, at Historical Cost	164,716		16
17	Accumulated Depreciation (book methods)	(91,308)		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	5,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 172,163	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,099,711	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,577,279	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	45,921		28
29	Short-Term Notes Payable	1,623,983		29
30	Accrued Salaries Payable	229,613		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,240		31
32	Accrued Real Estate Taxes(Sch.IX-B)	305,000		32
33	Accrued Interest Payable	8,914		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	93,047		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,913,997	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,913,997	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,185,714	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,099,711	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 747,247	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 747,247	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	549,117	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	183,350	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(294,000)	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)	\$ 438,467	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)	\$ 1,185,714	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,041,336	1
2	Discounts and Allowances for all Levels	314,730	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,356,066	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,125,465	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,125,465	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	326,026	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	34,972	19
20	Radiology and X-Ray	3,430	20
21	Other Medical Services	31,161	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 395,589	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	234	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 234	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	7,881	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,881	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,885,235	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,321,348	31
32	Health Care	2,984,457	32
33	General Administration	2,167,142	33
	B. Capital Expense		
34	Ownership	1,895,259	34
	C. Ancillary Expense		
35	Special Cost Centers	1,848,557	35
36	Provider Participation Fee	119,355	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,336,118	40
41	Income before Income Taxes (line 30 minus line 40)**	549,117	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 549,117	43

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

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

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

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

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	2,041	2,166	\$ 99,443	\$ 45.91	1
2	Assistant Director of Nursing	90	90	4,759	52.88	2
3	Registered Nurses	12,889	13,746	403,731	29.37	3
4	Licensed Practical Nurses	35,478	38,363	977,114	25.47	4
5	CNAs & Orderlies	72,622	78,846	834,982	10.59	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,971	5,302	110,966	20.93	8
9	Activity Director	1,961	2,102	34,666	16.49	9
10	Activity Assistants	10,754	11,367	107,420	9.45	10
11	Social Service Workers	2,721	3,039	47,354	15.58	11
12	Dietician					12
13	Food Service Supervisor	2,007	2,136	54,434	25.49	13
14	Head Cook	5,397	5,828	67,609	11.60	14
15	Cook Helpers/Assistants	13,429	14,855	142,163	9.57	15
16	Dishwashers					16
17	Maintenance Workers	1,822	2,096	52,240	24.92	17
18	Housekeepers	18,487	20,344	214,218	10.53	18
19	Laundry	7,126	7,840	79,029	10.08	19
20	Administrator	2,375	2,464	131,256	53.27	20
21	Assistant Administrator	2,453	2,544	42,542	16.72	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,526	8,985	158,316	17.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,198	1,280	26,798	20.93	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	206,348	223,395	\$ 3,589,040 *	\$ 16.07	34

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	463	\$ 25,510	01-03	35
36	Medical Director	Monthly	26,531	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	89,100	10-03	38
39	Pharmacist Consultant	Monthly	8,720	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	43	2,195	11-03	44
45	Social Service Consultant	110	5,461	12-03	45
46	Other(specify)				46
47	Restorative Therapy Consultant	Monthly	50	12-03	47
48					48
49	TOTAL (lines 35 - 48)	616	\$ 157,567		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

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

** See instructions.

Facility Name & ID Number		International Nursing And Rehab Center		STATE OF ILLINOIS		Report Period Beginning:		01/01/11		Page 21		Ending:		12/31/11			
XIX. SUPPORT SCHEDULES																	
A. Administrative Salaries				Ownership				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions					
Name		Function		%		Amount		Description		Amount		Description		Amount			
Chuck Slagel		Administrator		0		\$ 131,256		Workers' Compensation Insurance		\$ 69,607		IDPH License Fee		\$			
Mier Meystel (1/1/2011 - 6/30/2011)		Asst. Admin		0		25,180		Unemployment Compensation Insurance		166,935		Advertising: Employee Recruitment		665			
Shimmy Meystel (6/30/2011 - Present)		Asst. Admin		0		17,362		FICA Taxes		271,629		Health Care Worker Background Check					
								Employee Health Insurance		149,626		(Indicate # of checks performed 327)		3,270			
								Employee Meals		24,145		Patient Background Checks					
								Illinois Municipal Retirement Fund (IMRF)*				Dues & Subscriptions		19,665			
								Pension Expense		29,668		License & Permits		4,293			
								Employee Benefits Other		7,992		Allocated from YAM Management		760			
TOTAL (agree to Schedule V, line 17, col. 1)												Allocated from YAM Consulting				98	
(List each licensed administrator separately.)				\$ 173,798								See Supplemental Schedule				72	
B. Administrative - Other												Less: Public Relations Expense				()	
Description						Amount						Non-allowable advertising		()			
Management Fees - Yosef Meystel						\$ 21,000						Yellow page advertising		()			
Management Fees - David Berkowitz						33,000						TOTAL (agree to Sch. V,		\$ 28,823			
Admin Consulting - YAM Consulting,						2,500				\$ 719,602		line 20, col. 8)					
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 56,500				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**					
(Attach a copy of any management service agreement)																	
C. Professional Services																	
Vendor/Payee		Type				Amount		Description		Line #		Amount		Description		Amount	
Frost, Ruttenberg & Rothblatt		Accounting				\$ 35,865						\$		Out-of-State Travel		\$	
See Attached		Legal Fees				9,969											
LTC Solutions, Inc.		Data Processing				1,700											
Health Data Solutions, Inc.		Data Processing				4,741								In-State Travel			
E-Health Data Solutions		Data Processing				5,229											
Personnel Planners		Unemployment Consulting				3,724											
Allscripts		Computer Services				1,129											
ADAR		Data Processing				1,223								Seminar Expense		1,306	
American Data		Data Processing				10,585								Allocated from YAM Management		1,176	
Pathway Health Services		Consulting				53,074								Allocated from YAM Consulting		447	
IFMC		Quality Improvement				1,260											
See Supplemental Schedule						193,442								Entertainment Expense		()	
TOTAL (agree to Schedule V, line 19, column 3)				\$ 321,941				TOTAL				\$		(agree to Sch. V,			
(If total legal fees exceed \$5,000, attach copy of invoices.)														line 24, col. 8)			
														TOTAL			
														\$ 2,929			
* Attach copy of IMRF notifications																	
SEE ACCOUNTANTS' COMPILATION REPORT																	
**See instructions.																	

* 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

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:\$16,677 IAHCF:\$654

(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? _____

(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. \$ 24,099 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. \$ 119,355
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. \$ 24,145 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____

c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14

d. Have vehicle usage logs been maintained? No

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes

g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT