

Facility Name & ID Number Exceptional Care

0048496 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 08/06/10

	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	55	Skilled (SNF)	56	20,223	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	55	TOTALS	56	20,223	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	11,734	782	6,685	19,201	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,734	782	6,685	19,201	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.95%

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 10/01/2006

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/01/2006 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 56 and days of care provided 3,384

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/10

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

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	139,625	19,378	10,725	169,728		169,728	(6,090)	163,638		1
2	Food Purchase		95,280		95,280	(13,049)	82,231	(39)	82,192		2
3	Housekeeping	65,202	10,906		76,108		76,108		76,108		3
4	Laundry	25,440	7,105		32,545		32,545		32,545		4
5	Heat and Other Utilities			63,830	63,830		63,830	(2,696)	61,134		5
6	Maintenance	38,648	13,502	70,634	122,784		122,784	26,359	149,143		6
7	Other (specify):*							764	764		7
8	TOTAL General Services	268,915	146,171	145,189	560,275	(13,049)	547,226	18,298	565,524		8
	B. Health Care and Programs										
9	Medical Director			20,000	20,000		20,000		20,000		9
10	Nursing and Medical Records	896,439	63,896	74,480	1,034,815		1,034,815	(53,615)	981,200		10
10a	Therapy	418			418		418		418		10a
11	Activities	32,579	3,808	3,081	39,468		39,468		39,468		11
12	Social Services	39,806		1,302	41,108		41,108	101	41,209		12
13	CNA Training										13
14	Program Transportation			521	521		521	1,124	1,645		14
15	Other (specify):*							2,186	2,186		15
16	TOTAL Health Care and Programs	969,242	67,704	99,384	1,136,330		1,136,330	(50,204)	1,086,126		16
	C. General Administration										
17	Administrative	87,564		38,700	126,264		126,264	(19,090)	107,174		17
18	Directors Fees										18
19	Professional Services			165,584	165,584	(7,942)	157,642	(88,282)	69,360		19
20	Dues, Fees, Subscriptions & Promotions			14,313	14,313		14,313	(7,184)	7,129		20
21	Clerical & General Office Expenses	39,722	295	160,253	200,270		200,270	(90,571)	109,699		21
22	Employee Benefits & Payroll Taxes			256,438	256,438	13,049	269,487		269,487		22
23	Inservice Training & Education										23
24	Travel and Seminar			30	30		30	517	547		24
25	Other Admin. Staff Transportation			482	482		482	832	1,314		25
26	Insurance-Prop.Liab.Malpractice			280,147	280,147		280,147	686	280,833		26
27	Other (specify):*							7,659	7,659		27
28	TOTAL General Administration	127,286	295	915,947	1,043,528	5,107	1,048,635	(195,433)	853,201		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,365,443	214,170	1,160,520	2,740,133	(7,942)	2,732,191	(227,340)	2,504,851		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Exceptional Care

#0048496

Report Period Beginning:

01/01/10

Ending:

12/31/10

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			173,562	173,562		173,562	(142,988)	30,574			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			35,684	35,684		35,684	2,255	37,939			32
33	Real Estate Taxes			73,194	73,194	7,942	81,136	1,095	82,231			33
34	Rent-Facility & Grounds			245,500	245,500		245,500	(14,568)	230,932			34
35	Rent-Equipment & Vehicles			2,578	2,578		2,578	2,570	5,148			35
36	Other (specify):*											36
37	TOTAL Ownership			530,518	530,518	7,942	538,460	(151,635)	386,825			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		125,483	267,676	393,159		393,159	(74,324)	318,835			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,335	30,335		30,335		30,335			42
43	Other (specify):*	625		103,486	104,111		104,111	(104,111)				43
44	TOTAL Special Cost Centers	625	125,483	401,497	527,605		527,605	(178,435)	349,170			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,366,068	339,653	2,092,535	3,798,256		3,798,256	(557,411)	3,240,845			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care

0048496

Report Period Beginning:

01/01/10

Ending:

12/31/10

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,281)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(145,155)	30		9
10	Interest and Other Investment Income	(18)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(39)	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	(6,795)	21		18
19	Entertainment	(4,446)	21		19
20	Contributions	(3,900)	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	(92,614)	21		24
25	Fund Raising, Advertising and Promotional	(1,525)	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	(160,726)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (418,499)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(138,911)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (138,911)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (557,411)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Exceptional Care

ID# 0048496

Report Period Beginning: 01/01/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Pharmacy - Veteran	\$ (41)	10	1
2	Marketing Salary	(625)	43	2
3	Bank Charges	(23,076)	21	3
4	COPE Dues	(1,978)	20	4
5	Other Marketing	(1,786)	43	5
6	Non-Allowable Legal	(5,038)	19	6
7	Additional R&M	24,891	06	7
8	Pharmacy Medicare Income	(74,324)	39	8
9	Non-Allowable Fees	(78,000)	43	9
10	Non-Allowable Professional	(749)	19	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(160,726)		49

Exceptional Care

ID# 0048496

Report Period Beginning: 01/01/10

Ending: 12/31/10

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Exceptional Care# 0048496

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				(6,090)								(6,090)	1
2	Food Purchase	(39)											(39)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(3,281)		585									(2,696)	5
6	Maintenance	24,891		1,442		26							26,359	6
7	Other (specify):*			226	538								764	7
8	TOTAL General Services	21,571		2,253	(5,552)	26							18,298	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(41)			(53,574)								(53,615)	10
10a	Therapy													10a
11	Activities													11
12	Social Services				101								101	12
13	CNA Training													13
14	Program Transportation				1,124								1,124	14
15	Other (specify):*				2,186								2,186	15
16	TOTAL Health Care and Programs	(41)			(50,163)								(50,204)	16
	C. General Administration													
17	Administrative			4,055	(23,145)								(19,090)	17
18	Directors Fees													18
19	Professional Services	(5,787)		(78,563)	(4,867)	935							(88,282)	19
20	Fees, Subscriptions & Promotions	(7,403)		144	26	49							(7,184)	20
21	Clerical & General Office Expenses	(126,931)		32,542	3,796	22							(90,571)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			174	343								517	24
25	Other Admin. Staff Transportation			728	104								832	25
26	Insurance-Prop.Liab.Malpractice			686									686	26
27	Other (specify):*			6,646	1,013								7,659	27
28	TOTAL General Administration	(140,121)		(33,588)	(22,730)	1,006							(195,433)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(118,591)		(31,335)	(78,446)	1,031							(227,340)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Exceptional Care# 0048496

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(145,155)		1,681	19	467							(142,988)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(18)		12		2,261							2,255	32
33	Real Estate Taxes			1,040		55							1,095	33
34	Rent-Facility & Grounds			(9,434)		(5,134)							(14,568)	34
35	Rent-Equipment & Vehicles			627	1,943								2,570	35
36	Other (specify):*													36
37	TOTAL Ownership	(145,173)		(6,074)	1,962	(2,350)							(151,635)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(74,324)											(74,324)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(80,411)			(23,700)								(104,111)	43
44	TOTAL Special Cost Centers	(154,735)			(23,700)								(178,435)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(418,499)		(37,408)	(100,184)	(1,319)							(557,411)	45

VII. RELATED PARTIES

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

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

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	YAM MANAGEMENT, LLC	100.00%	\$ 585	\$	585	15
16	V	6 REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	1,442		1,442	16
17	V	7 EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	226		226	17
18	V	17 ADMIN. - RELATED		YAM MANAGEMENT, LLC	100.00%	2,874		2,874	18
19	V	17 ADMIN. - NON RELATED		YAM MANAGEMENT, LLC	100.00%	1,181		1,181	19
20	V	19 PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	2,605		2,605	20
21	V	20 FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	144		144	21
22	V	21 CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	32,542		32,542	22
23	V	24 SEMINARS		YAM MANAGEMENT, LLC	100.00%	174		174	23
24	V	25 AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	728		728	24
25	V	26 INSURANCE		YAM MANAGEMENT, LLC	100.00%	686		686	25
26	V	27 EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	6,646		6,646	26
27	V	30 DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	1,681		1,681	27
28	V	32 INTEREST		YAM MANAGEMENT, LLC	100.00%	12		12	28
29	V	33 REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%	1,040		1,040	29
30	V	34 RENT		YAM MANAGEMENT, LLC	100.00%	6,066		6,066	30
31	V	35 AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	361		361	31
32	V	35 EQUIPMENT RENTAL		YAM MANAGEMENT, LLC	100.00%	266		266	32
33	V								33
34	V								34
35	V	19 BOOKKEEPING FEES	45,168	YAM MANAGEMENT, LLC	100.00%			(45,168)	35
36	V	19 ACCOUNTING	36,000	YAM MANAGEMENT, LLC	100.00%			(36,000)	36
37	V	34 RENT	15,500	YAM MANAGEMENT, LLC	100.00%			(15,500)	37
38	V								38
39	Total		\$ 96,668			\$ 59,260	\$ *	(37,408)	39

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

Facility Name & ID Number

Exceptional Care

0048496

Report Period Beginning:

01/01/10

Ending:

12/31/10

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1	DIETARY	YAM CONSULTING, LLC	100.00%	\$ 4,635	\$ 4,635
16	V	7	EMP. BEN. GEN. SERV.	YAM CONSULTING, LLC	100.00%	538	538
17	V	10	NURSING SALARY	YAM CONSULTING, LLC	100.00%	17,424	17,424
18	V	12	SOCIAL SERVICES SALARY	YAM CONSULTING, LLC	100.00%	101	101
19	V	14	PROGRAM TRANSPORTATION	YAM CONSULTING, LLC	100.00%	1,124	1,124
20	V	15	EMP. BEN. HEALTHCARE	YAM CONSULTING, LLC	100.00%	2,186	2,186
21	V	17	ADMIN. - NON RELEATED	YAM CONSULTING, LLC	100.00%	3,555	3,555
22	V	19	PROFESSIONAL FEES	YAM CONSULTING, LLC	100.00%	89	89
23	V	20	FEES, SUBSCRIPTIONS	YAM CONSULTING, LLC	100.00%	26	26
24	V	21	CLERICAL & GENERAL	YAM CONSULTING, LLC	100.00%	3,796	3,796
25	V	24	SEMINARS	YAM CONSULTING, LLC	100.00%	343	343
26	V	25	AUTO AND TRAVEL	YAM CONSULTING, LLC	100.00%	104	104
27	V	27	EMP. BEN.-GEN. ADMIN.	YAM CONSULTING, LLC	100.00%	1,013	1,013
28	V	30	DEPRECIATION	YAM CONSULTING, LLC	100.00%	19	19
29	V	35	AUTO RENTAL	YAM CONSULTING, LLC	100.00%	1,943	1,943
30	V						
31	V						
32	V						
33	V	01	DIETICIAN CONSULTING	YAM CONSULTING, LLC	100.00%		(10,725)
34	V	10	RN CONSULTING	YAM CONSULTING, LLC	100.00%		(70,998)
35	V	17	DIR. OF OPERATIONS CONSULT	YAM CONSULTING, LLC	100.00%		(26,700)
36	V	19	DATA PROCESSING FEES	YAM CONSULTING, LLC	100.00%		(4,956)
37	V	43	MARKETING	YAM CONSULTING, LLC	100.00%		(23,700)
38	V						
39	Total		\$ 137,079			\$ 36,895	\$ * (100,184)

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 REPAIRS & MAINTENANCE	\$	8131 N. MONTICELLO, LLC	100.00%	\$ 26	\$	26	15
16	V	19 PROFESSIONAL FEES		8131 N. MONTICELLO, LLC	100.00%	935		935	16
17	V	20 DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC	100.00%	49		49	17
18	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC	100.00%	22		22	18
19	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC	100.00%	467		467	19
20	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC	100.00%	2,261		2,261	20
21	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC	100.00%	1,095		1,095	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34 RENT	5,134	8131 N. MONTICELLO, LLC	100.00%			(5,134)	26
27	V	33 R/E Taxes	1,040	8131 N. MONTICELLO, LLC	100.00%			(1,040)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 6,174			\$ 4,855	\$ *	(1,319)	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Exceptional Care # **0048496** Report Period Beginning: **01/01/10** Ending: **12/31/10**

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Owner	Administrative	96.00%	See Attached	1.4	3.50%	Mgmt. Fees	\$ 12,000	17-3	1
2	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.7	1.75%	Alloc. Salary	1,988	17-7	2
3	Joel Meystel	Relative	Administrative	0.00%	See Attached	0.7	3.50%	Alloc. Salary	886	17-7	3
4	Shimon Meystel	Relative	Clerical	0.00%	See Attached	1.4	3.50%	Alloc. Salary	471	21-7	4
5											5
6											6
7	Where Applicable, The Amounts Reported On This Page Have Been Adjusted From The Actual Costs To Reflect Only Amounts Anticipated To Be Considered Allowable										7
8	By The IL. Department of HFS										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 15,345		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 Exceptional Care # 0048496 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care

0048496

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

YAM MANAGEMENT, LLC

Street Address

8131 N. MONTICELLO

City / State / Zip Code

SKOKIE, ILLINOIS 60076

Phone Number

(847) 673-6767

Fax Number

(847) 673-6768

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	AVAIL. BED DAYS	579,474	16	\$ 16,764	\$ 20,223	\$ 585	1	
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	579,474	16	41,306	29,925	20,223	1,442	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	579,474	16	6,478	20,223	226	3	
4	17	ADMIN. - RELATED	AVAIL. BED DAYS	579,474	16	82,362	82,362	20,223	2,874	4
5	17	ADMIN. - NON RELATED	AVAIL. BED DAYS	579,474	16	33,843	33,843	20,223	1,181	5
6	19	PROFESSIONAL FEES	AVAIL. BED DAYS	579,474	16	74,656	20,223	2,605	6	
7	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	579,474	16	4,114	20,223	144	7	
8	21	CLERICAL & GENERAL	AVAIL. BED DAYS	579,474	16	932,452	841,703	20,223	32,542	8
9	24	SEMINARS	AVAIL. BED DAYS	579,474	16	4,974	20,223	174	9	
10	25	AUTO AND TRAVEL	AVAIL. BED DAYS	579,474	16	20,872	20,223	728	10	
11	26	INSURANCE	AVAIL. BED DAYS	579,474	16	19,661	20,223	686	11	
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	579,474	16	190,434	20,223	6,646	12	
13	30	DEPRECIATION	AVAIL. BED DAYS	579,474	16	48,156	20,223	1,681	13	
14	32	INTEREST	AVAIL. BED DAYS	579,474	16	331	20,223	12	14	
15	33	REAL ESTATE TAX	AVAIL. BED DAYS	579,474	16	29,806	20,223	1,040	15	
16	34	RENT	AVAIL. BED DAYS	579,474	16	173,825	20,223	6,066	16	
17	35	AUTO RENTAL	AVAIL. BED DAYS	579,474	16	10,347	20,223	361	17	
18	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	579,474	16	7,632	20,223	266	18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,698,015	\$ 987,832	\$ 59,260	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care

0048496

Report Period Beginning:

01/01/10

Ending: 12/31/10

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY	AVAIL. BED DAYS	579,474	16	\$ 132,801	\$ 123,648	20,223	\$ 4,635	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	579,474	16	15,402		20,223	538	2
3	10	NURSING SALARY	AVAIL. BED DAYS	579,474	16	499,281	499,281	20,223	17,424	3
4	12	SOCIAL SERVICES SALARY	AVAIL. BED DAYS	579,474	16	2,888	2,888	20,223	101	4
5	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	579,474	16	32,206		20,223	1,124	5
6	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	579,474	16	62,625		20,223	2,186	6
7	17	ADMIN. - NON RELEATED	AVAIL. BED DAYS	579,474	16	101,866	101,866	20,223	3,555	7
8	19	PROFESSIONAL FEES	AVAIL. BED DAYS	579,474	16	2,550		20,223	89	8
9	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	579,474	16	755		20,223	26	9
10	21	CLERICAL & GENERAL	AVAIL. BED DAYS	579,474	16	108,757	86,009	20,223	3,796	10
11	24	SEMINARS	AVAIL. BED DAYS	579,474	16	9,816		20,223	343	11
12	25	AUTO AND TRAVEL	AVAIL. BED DAYS	579,474	16	2,967		20,223	104	12
13	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	579,474	16	29,022		20,223	1,013	13
14	30	DEPRECIATION	AVAIL. BED DAYS	579,474	16	539		20,223	19	14
15	35	AUTO RENTAL	AVAIL. BED DAYS	579,474	16	55,686		20,223	1,943	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,057,162	\$ 813,692		\$ 36,895	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	REPAIRS & MAINTENANCE	PATIENT DAYS	579,474	16	\$ 732	20,223	\$ 26	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	579,474	16	26,780	20,223	935	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	579,474	16	1,405	20,223	49	3
4	21	OFFICE EXPENSE	PATIENT DAYS	579,474	16	630	20,223	22	4
5	30	DEPRECIATION	PATIENT DAYS	579,474	16	13,389	20,223	467	5
6	32	INTEREST EXPENSE	PATIENT DAYS	579,474	16	64,796	20,223	2,261	6
7	33	REAL ESTATE TAXES	PATIENT DAYS	579,474	16	31,375	20,223	1,095	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 139,107	\$	\$ 4,855	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care

0048496

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care

0048496

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care

0048496 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Exceptional Care

0048496

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

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

	1	2	3	4	5	6		8	9	10									
						Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES							NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term																		
	Working Capital																		
8	Shareholders/Partners		X	Working Capital			\$	\$ 60,000			\$	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital																		
	B. Non-Facility Related*																		
15	Allocated From 8131 Monticello		X				\$	\$			\$ 2,261	15							
16												16							
17												17							
18												18							
19												19							
20	TOTAL Non-Facility Related																		

* 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 2009 report.		\$	128,909	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.)		\$	101,892	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(27,017)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	101,306	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.)		\$	7,942	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.		\$	82,231	7

Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2005		8	
	2006	120,838	9	
	2007	122,802	10	
	2008	124,389	11	
	2009	100,797	12	

2010 Accrual = \$100,797 X 1.01 = \$101306 (Rounded)				
Allocated From 8131 N. Monticello = \$1,095				

	FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2009	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care

0048496

Report Period Beginning:

01/01/10

Ending:

12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,728 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care

0048496

Report Period Beginning:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)

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

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

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

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

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68			44,081	480	699	219	770	68
69				173,562		(173,562)		69
70		\$	\$ 44,081	\$ 174,042	\$ 699	\$ (173,343)	\$ 770	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 44,081	\$ 174,042		\$ 699	\$ (173,343)	\$ 770	1
2	Altern. Energy Solutions Install	2007	4,773		20	318	318	1,114	2
3	Chesterfield Awning	2007			20				3
4	Sherwin Williams Wallpaper	2008	3,484		20			3,484	4
5	Judicial Receivers Corp. Painting	2008			20				5
6	Judicial Receivers Wallcovering	2008	10,800		20			10,800	6
7	Ltc Solutions/Econocare - Flooring, Handrails, Window Treatmen	2008	27,945		20	2,794	2,794	7,219	7
8	Seco Refrigeration - Hot Water Heater	2008	5,492		20	458	458	1,030	8
9	Satellite America	2008	3,700		20	370	370	802	9
10	Upholstery, Curtains	2009	19,654		20	3,931	3,931	5,896	10
11	Econocare Handrails, Crashrail, Cornerguards	2009	12,223		20	1,222	1,222	1,324	11
12	Heating Units & Hot Water Valve	2009	2,962		20	148	148	284	12
13	Cabinets, Reception Desk, Wardrobes & Window Treatments	2010	44,111		20	1,469	1,469	1,469	13
14	Bathroom - Ceramic Wall & Tile, Plumbing Fixtures, Grab Bars	2010	24,500		20	816	816	816	14
15	Awning Reupholstered	2010	6,425		20	134	134	134	15
16	Corner Guards	2010	2,951		20	98	98	98	16
17	Existing Vct & Cove Base Removal, Pvt & Millwork Base Install	2010	18,886		20	629	629	629	17
18	Therapy Rm -Baseboard, Cove Base & Vct, Tile, Millwork Base	2010	7,909		20	263	263	263	18
19	Cove Base Take Up & Millwork Base; Window Treatments	2010	2,795		20	93	93	93	19
20	Medication/Therapy Rooms - Cabinets, Countertops	2010	9,091		20	303	303	303	20
21	Heating Duct Furnace	2010	7,778		20	259	259	259	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)		\$ 259,561	\$ 174,042		\$ 14,005	\$ (160,037)	\$ 36,787	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 259,561	\$ 174,042		\$ 14,005	\$ (160,037)	\$ 36,787	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		\$ 259,561	\$ 174,042		\$ 14,005	\$ (160,037)	\$ 36,787	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 259,561	\$ 174,042		\$ 14,005	\$ (160,037)	\$ 36,787	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)	\$ 259,561	\$ 174,042		\$ 14,005	\$ (160,037)	\$ 36,787	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 259,561	\$ 174,042		\$ 14,005	\$ (160,037)	\$ 36,787	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)	\$ 259,561	\$ 174,042		\$ 14,005	\$ (160,037)	\$ 36,787	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	<u>Allocated From 8131 N. Monticello LLC</u>	2010	31,096	329	39	329		329	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	<u>Allocated From YAM Management, LLC</u>	2007	747	2	20	37	35	117	9
10	<u>Allocated From YAM Management, LLC</u>	2008	51	1	20	2	1	2	10
11	<u>Allocated From YAM Management, LLC</u>	2009	227	3	20	9	6		11
12	<u>Allocated From YAM Management, LLC</u>	2010	1,150	7	20	31	24	31	12
13									13
14	<u>Allocated From 8131 N. Monticello LLC</u>	2010	10,810	138	20	291	153	291	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)	\$ 44,081	\$ 480		\$ 699	\$ 219	\$ 770	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 Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 79,183	\$ 482	\$ 13,246	\$ 12,764	10	\$ 50,358	71
72	Current Year Purchases	14,928	1,111	3,177	2,066	10	3,177	72
73	Fully Depreciated Assets	11,329				10	11,329	73
74								74
75	TOTALS	\$ 105,440	\$ 1,593	\$ 16,422	\$ 14,829		\$ 64,864	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated From YAM Mgmt	2009	\$ 825	\$ 94	\$ 147	\$ 53	5	\$ 481	76
77										77
78										78
79										79
80	TOTALS			\$ 825	\$ 94	\$ 147	\$ 53		\$ 481	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 365,826	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 175,729	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 30,574	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (145,155)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 102,133	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: Sunset Building LLC

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

If NO, see instructions. YES NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	56		\$ 230,000			3
4	Additions						4
5							5
6	Allocated From YAM Management			932			6
7	TOTAL	56		\$ 230,932			7

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

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

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

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 2,844 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	Allocated From YAM Management		\$	361	17
18	Allocated From YAM Consulting			1,943	18
19					19
20					20
21	TOTAL		\$	2,304	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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

Facility Name & ID Number Exceptional Care

0048496

Report Period Beginning: 01/01/10

Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 13,633	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	679,438		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	78,222		6
7	Other Prepaid Expenses	1,125		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	166,586		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 939,004	\$	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	207,014		15
16	Equipment, at Historical Cost	154,418		16
17	Accumulated Depreciation (book methods)	(248,590)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	107,315		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 220,157	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,159,161	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 419,531	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,928		28
29	Short-Term Notes Payable	915,922		29
30	Accrued Salaries Payable	74,027		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,728		31
32	Accrued Real Estate Taxes(Sch.IX-B)	101,306		32
33	Accrued Interest Payable	2,363		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	567,023		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,090,828	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,090,828	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (931,667)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,159,161	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (915,221)	1
2	Restatements (describe):		2
3	Rounding Adjustment	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (915,222)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(16,445)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (16,445)	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)	\$ (931,667)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care# 0048496Report Period Beginning: 01/01/10Ending: 12/31/10

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,679,396	1
2	Discounts and Allowances for all Levels	(736,757)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,942,639	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	632,354	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 632,354	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	111,044	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,037	19
20	Radiology and X-Ray	1,405	20
21	Other Medical Services	9,989	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 132,475	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	18	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 18	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	74,325	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 74,325	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,781,811	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	560,275	31
32	Health Care	1,136,330	32
33	General Administration	1,043,528	33
B. Capital Expense			
34	Ownership	530,518	34
C. Ancillary Expense			
35	Special Cost Centers	497,270	35
36	Provider Participation Fee	30,335	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,798,256	40
41	Income before Income Taxes (line 30 minus line 40)**	(16,445)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (16,445)	43

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

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

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

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

Facility Name & ID Number Exceptional Care

0048496

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,013	2,058	\$ 76,673	\$ 37.26	1
2	Assistant Director of Nursing	21	25	739	29.56	2
3	Registered Nurses	2,865	3,115	95,434	30.64	3
4	Licensed Practical Nurses	9,807	10,629	290,338	27.32	4
5	CNAs & Orderlies	28,794	31,724	368,319	11.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	33	36	418	11.61	8
9	Activity Director					9
10	Activity Assistants	3,534	3,741	32,579	8.71	10
11	Social Service Workers	2,770	2,904	39,806	13.71	11
12	Dietician					12
13	Food Service Supervisor	1,893	2,090	35,163	16.82	13
14	Head Cook	3,849	4,241	59,820	14.11	14
15	Cook Helpers/Assistants	4,097	4,433	44,642	10.07	15
16	Dishwashers					16
17	Maintenance Workers	1,997	2,158	38,648	17.91	17
18	Housekeepers	6,327	6,718	65,202	9.71	18
19	Laundry	2,515	2,711	25,440	9.38	19
20	Administrator	2,063	2,166	87,564	40.43	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,404	3,686	39,722	10.78	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	1,949	2,090	64,936	31.07	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	40	40	625	15.63	33
34	TOTAL (lines 1 - 33)	77,971	84,565	\$ 1,366,068 *	\$ 16.15	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	256	\$ 10,725	01-03	35
36	Medical Director	Monthly	20,000	09-03	36
37	Medical Records Consultant	Monthly	1,110	10-03	37
38	Nurse Consultant	1,407	70,998	10-03	38
39	Pharmacist Consultant	64	2,372	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	145	3,081	11-03	44
45	Social Service Consultant	Monthly	1,302	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,872	\$ 109,588		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Akeem Abiola	Administrator	0.00%	\$ 87,564	Workers' Compensation Insurance	\$ 40,664	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	40,822	Advertising: Employee Recruitment	25	
				FICA Taxes	101,985	Health Care Worker Background Check	1,160	
				Employee Health Insurance	57,172	(Indicate # of checks performed <u>116</u>)		
				Employee Meals	13,049	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	2,948	
				Pension Plan Contribution	15,796	Licenses & Permits	1,782	
						Advertising and Promotion	1,525	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 87,564			See Supplemental Schedule	219	
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	(1,525)	
Management Fee - Yosef Meystel			\$ 12,000			Yellow page advertising	()	
YAM Consulting - Director of Operations Consultant			26,700					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 38,700	TOTAL (agree to Schedule V, line 22, col.8)	\$ 269,488	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 7,129	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Frost, Ruttenberg & Rothblatt	Accounting		\$ 19,525				Out-of-State Travel	\$
YAM Consulting	Data Processing		4,956					
YAM Management	Accounting		36,000					
E-Health Data Solutions	Data Processing		3,647				In-State Travel	
Personnel Planners	Unemployment Consulting		1,250					
First Real Estate	R/E Appraisal		750					
YAM Management	Bookkeeping		45,168					
See Attached	Legal		34,627				Seminar Expense	30
Skidelsky & Associates	R/E Appeal		7,192				Allocated From YAM Management	174
Adj. on Page 5a	Legal		5,038				Allocated From YAM Consulting	343
American Data	Data Processing		2,977					
See Supplemental Schedule			4,455				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 165,585	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 547

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care

0048496

Report Period Beginning:

01/01/10

Ending:

12/31/10

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$2,063; IL Assoc of HC \$660
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,844 Line 10-02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? X YES NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 30,335
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. \$ 13,049 Has any meal income been offset against related costs? None Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.