

Facility Name & ID Number Exceptional Care

0048496 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>56</u>	Skilled (SNF)	<u>56</u>	<u>20,440</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>56</u>	TOTALS	<u>56</u>	<u>20,440</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	<u>14,228</u>	<u>1,350</u>	<u>3,686</u>	<u>19,264</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>14,228</u>	<u>1,350</u>	<u>3,686</u>	<u>19,264</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.25%

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 2,713

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: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number Exceptional Care # 0048496 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	134,706	23,756	15,483	173,945		173,945	(11,534)	162,411		1
2	Food Purchase		96,858		96,858	(13,231)	83,627	(68)	83,559		2
3	Housekeeping	81,446	11,502		92,948		92,948		92,948		3
4	Laundry	14,863	7,446		22,309		22,309		22,309		4
5	Heat and Other Utilities			78,987	78,987		78,987	(7,284)	71,703		5
6	Maintenance	39,507	20,448	54,394	114,349		114,349	15,075	129,424		6
7	Other (specify):*							527	527		7
8	TOTAL General Services	270,522	160,010	148,864	579,396	(13,231)	566,165	(3,284)	562,881		8
	B. Health Care and Programs										
9	Medical Director			26,000	26,000		26,000		26,000		9
10	Nursing and Medical Records	845,349	40,129	81,837	967,315		967,315	(60,414)	906,901		10
10a	Therapy										10a
11	Activities	36,868	2,659	1,200	40,727		40,727		40,727		11
12	Social Services	30,243		3,180	33,423		33,423		33,423		12
13	CNA Training										13
14	Program Transportation			59	59		59	1,141	1,200		14
15	Other (specify):*							2,214	2,214		15
16	TOTAL Health Care and Programs	912,460	42,788	112,276	1,067,524		1,067,524	(57,059)	1,010,465		16
	C. General Administration										
17	Administrative	78,634		26,598	105,232		105,232	4,851	110,083		17
18	Directors Fees										18
19	Professional Services			162,865	162,865	(15,070)	147,795	(84,332)	63,463		19
20	Dues, Fees, Subscriptions & Promotions			22,199	22,199		22,199	(8,931)	13,268		20
21	Clerical & General Office Expenses	46,327	1,143	347,054	394,524		394,524	(311,020)	83,504		21
22	Employee Benefits & Payroll Taxes			256,208	256,208	13,231	269,439		269,439		22
23	Inservice Training & Education										23
24	Travel and Seminar			850	850		850	417	1,267		24
25	Other Admin. Staff Transportation			914	914		914	1,042	1,956		25
26	Insurance-Prop.Liab.Malpractice			103,605	103,605		103,605	629	104,234		26
27	Other (specify):*							7,929	7,929		27
28	TOTAL General Administration	124,961	1,143	920,293	1,046,397	(1,838)	1,044,559	(389,415)	655,144		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,307,943	203,941	1,181,433	2,693,317	(15,070)	2,678,247	(449,758)	2,228,489		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:

01/01/11

Ending:

12/31/11

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			48,425	48,425		48,425	(16,173)	32,252			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			48,304	48,304		48,304	1,573	49,877			32
33	Real Estate Taxes			102,007	102,007	15,070	117,077	865	117,942			33
34	Rent-Facility & Grounds			245,200	245,200		245,200	(13,000)	232,200			34
35	Rent-Equipment & Vehicles			1,039	1,039		1,039	2,571	3,610			35
36	Other (specify):*											36
37	TOTAL Ownership			444,975	444,975	15,070	460,045	(24,164)	435,881			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		99,657	241,995	341,652		341,652		341,652			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,660	30,660		30,660		30,660			42
43	Other (specify):*			172,083	172,083		172,083	(172,083)				43
44	TOTAL Special Cost Centers		99,657	444,738	544,395		544,395	(172,083)	372,312			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,307,943	303,598	2,071,146	3,682,687		3,682,687	(646,005)	3,036,682			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:

01/01/11

Ending:

12/31/11

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	(7,736)	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	(18,221)	30		9
10	Interest and Other Investment Income	(97)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(68)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,730)	21		18
19	Entertainment	(2,546)	21		19
20	Contributions	(8,100)	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	(282,545)	21		24
25	Fund Raising, Advertising and Promotional	(820)	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	(194,952)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (517,815)		\$	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)	(128,190)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (128,190)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (646,005)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Exceptional Care

ID# 0048496

Report Period Beginning: 01/01/11

Ending: 12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Additional R&M	\$ 14,306	06	1
2	Bank Charges	(35,484)	21	2
3	Marketing Fees	(17,533)	43	3
4	Jury Duty Income	(17)	21	4
5	Miscellaneous Income	(1,424)	21	5
6	Non-Allowable Fees	(154,550)	43	6
7	Annual Report Filing Fee	(250)	20	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				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	(194,952)		49

Exceptional Care

ID# 0048496
 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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Exceptional Care# 0048496

Report Period Beginning:

01/01/11

Ending:

12/31/11

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				(11,534)								(11,534)	1
2	Food Purchase	(68)											(68)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(7,736)		452									(7,284)	5
6	Maintenance	14,306		769									15,075	6
7	Other (specify):*			54	473								527	7
8	TOTAL General Services	6,502		1,275	(11,061)								(3,284)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				(60,414)								(60,414)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation				1,141								1,141	14
15	Other (specify):*				2,214								2,214	15
16	TOTAL Health Care and Programs				(57,059)								(57,059)	16
	C. General Administration													
17	Administrative			10,616	(5,765)								4,851	17
18	Directors Fees													18
19	Professional Services			(81,077)	(3,409)	154							(84,332)	19
20	Fees, Subscriptions & Promotions	(9,170)		195	25	19							(8,931)	20
21	Clerical & General Office Expenses	(324,746)		26,507	(12,811)	30							(311,020)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			302	115								417	24
25	Other Admin. Staff Transportation			878	164								1,042	25
26	Insurance-Prop.Liab.Malpractice			629									629	26
27	Other (specify):*			7,027	902								7,929	27
28	TOTAL General Administration	(333,916)		(34,923)	(20,779)	203							(389,415)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(327,414)		(33,648)	(88,899)	203							(449,758)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Exceptional Care# 0048496

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	(18,221)		494	20	1,534							(16,173)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(97)		30		1,640							1,573	32
33	Real Estate Taxes			1,382		(517)							865	33
34	Rent-Facility & Grounds			(8,357)		(4,643)							(13,000)	34
35	Rent-Equipment & Vehicles			728	1,843								2,571	35
36	Other (specify):*													36
37	TOTAL Ownership	(18,318)		(5,723)	1,863	(1,986)							(24,164)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(172,083)											(172,083)	43
44	TOTAL Special Cost Centers	(172,083)											(172,083)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(517,815)		(39,371)	(87,036)	(1,783)							(646,005)	45

VII. RELATED PARTIES

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

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

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%	\$ 452	\$	452	15
16	V	6 REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	769		769	16
17	V	7 EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	54		54	17
18	V	17 ADMINISTRATIVE		YAM MANAGEMENT, LLC	100.00%	10,616		10,616	18
19	V	19 PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	793		793	19
20	V	20 FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	195		195	20
21	V	21 CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	26,507		26,507	21
22	V	24 SEMINARS		YAM MANAGEMENT, LLC	100.00%	302		302	22
23	V	25 AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	878		878	23
24	V	26 INSURANCE		YAM MANAGEMENT, LLC	100.00%	629		629	24
25	V	27 EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	7,027		7,027	25
26	V	30 DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	494		494	26
27	V	32 INTEREST		YAM MANAGEMENT, LLC	100.00%	30		30	27
28	V	33 REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%	1,382		1,382	28
29	V	34 RENT		YAM MANAGEMENT, LLC	100.00%	4,643		4,643	29
30	V	35 AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	538		538	30
31	V	35 EQUIPMENT RENTAL		YAM MANAGEMENT, LLC	100.00%	190		190	31
32	V	0		YAM MANAGEMENT, LLC	100.00%				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	13,000	YAM MANAGEMENT, LLC	100.00%			(13,000)	37
38	V	19 DATA PROCESSING	702	YAM MANAGEMENT, LLC	100.00%			(702)	38
39	Total		\$ 94,870			\$ 55,499	\$ *	(39,371)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	<u>1</u> <u>DIETARY</u>	\$	<u>YAM CONSULTING, LLC</u>	100.00%	\$ 3,949	\$ 3,949
16	V	<u>7</u> <u>EMP. BEN. GEN. SERV.</u>		<u>YAM CONSULTING, LLC</u>	100.00%	473	473
17	V	<u>10</u> <u>NURSING SALARY</u>		<u>YAM CONSULTING, LLC</u>	100.00%	17,784	17,784
18	V	<u>14</u> <u>PROGRAM TRANSPORTATION</u>		<u>YAM CONSULTING, LLC</u>	100.00%	1,141	1,141
19	V	<u>15</u> <u>EMP. BEN. HEALTHCARE</u>		<u>YAM CONSULTING, LLC</u>	100.00%	2,214	2,214
20	V	<u>17</u> <u>ADMINISTRATIVE</u>		<u>YAM CONSULTING, LLC</u>	100.00%	5,833	5,833
21	V	<u>19</u> <u>PROFESSIONAL FEES</u>		<u>YAM CONSULTING, LLC</u>	100.00%	1,547	1,547
22	V	<u>20</u> <u>FEES, SUBSCRIPTIONS</u>		<u>YAM CONSULTING, LLC</u>	100.00%	25	25
23	V	<u>21</u> <u>CLERICAL & GENERAL</u>		<u>YAM CONSULTING, LLC</u>	100.00%	3,189	3,189
24	V	<u>24</u> <u>SEMINARS</u>		<u>YAM CONSULTING, LLC</u>	100.00%	115	115
25	V	<u>25</u> <u>AUTO AND TRAVEL</u>		<u>YAM CONSULTING, LLC</u>	100.00%	164	164
26	V	<u>27</u> <u>EMP. BEN.-GEN. ADMIN.</u>		<u>YAM CONSULTING, LLC</u>	100.00%	902	902
27	V	<u>30</u> <u>DEPRECIATION</u>		<u>YAM CONSULTING, LLC</u>	100.00%	20	20
28	V	<u>35</u> <u>AUTO RENTAL</u>		<u>YAM CONSULTING, LLC</u>	100.00%	1,843	1,843
29	V	<u>0</u>					
30	V						
31	V						
32	V	<u>0</u>					
33	V	<u>01</u> <u>DIETICIAN CONSULTING</u>	15,483	<u>YAM CONSULTING, LLC</u>	100.00%		(15,483)
34	V	<u>10</u> <u>NURSE CONSULTING</u>	78,198	<u>YAM CONSULTING, LLC</u>	100.00%		(78,198)
35	V	<u>17</u> <u>DIR. OF OPERATIONS CONSULT</u>	11,598	<u>YAM CONSULTING, LLC</u>	100.00%		(11,598)
36	V	<u>19</u> <u>DATA PROCESSING FEES</u>	4,956	<u>YAM CONSULTING, LLC</u>	100.00%		(4,956)
37	V	<u>21</u> <u>MARKETING</u>	16,000	<u>YAM CONSULTING, LLC</u>	100.00%		(16,000)
38	V						
39	Total		\$ 126,235			\$ 39,199	\$ * (87,036)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19 PROFESSIONAL FEES	\$	8131 N. MONTICELLO, LLC	100.00%	\$ 154	\$	154	15
16	V	20 DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC	100.00%	19		19	16
17	V	21 OFFICE EXPENSE		8131 N. MONTICELLO, LLC	100.00%	30		30	17
18	V	30 DEPRECIATION		8131 N. MONTICELLO, LLC	100.00%	1,534		1,534	18
19	V	32 INTEREST EXPENSE		8131 N. MONTICELLO, LLC	100.00%	1,640		1,640	19
20	V	33 REAL ESTATE TAXES		8131 N. MONTICELLO, LLC	100.00%	865		865	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34 RENT	4,643	8131 N. MONTICELLO, LLC	100.00%			(4,643)	26
27	V	33 R/E Taxes	1,382	8131 N. MONTICELLO, LLC	100.00%			(1,382)	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		\$ 6,025			\$ 4,242	\$ *	(1,783)	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

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	10.000%	BERKSHIRE NURSING & REHAB CENTER,LLC	FOREST PARK	YAM MANAGEMENT	SKOKIE	MANAGEMENT CO.	1
2	257 LIMITED PARTNERSHIP	19.000%	CONCORD NURSING AND REHABILITATION CENTER,LLC	OAK LAWN	YAM CONSULTING	SKOKIE	CONSULTING CO.	2
3	350 LIMITED PARTNERSHIP	1.000%	DOLTON NURSING & REHAB,LLC	DOLTON	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDIN	3
4	42170 LIMITED PARTNERSHIP	10.000%	EVANSTON NURSING & REHAB CENTER, LLC	EVANSTON				4
5	YOSEF MEYSEL	60.000%	FAIRVIEW CARE CENTER OF JOLIET,LLC	JOLIET				5
6			HIGHLAND PARK NURSING AND REHAB CENTER, LLC	HIGHWOOD				6
7			INTERNATIONAL NURSING & REHAB CENTER,LLC	CHICAGO				7
8			JACKSONVILLE CARE CENTER	JACKSONVILLE				8
9			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								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

VII. RELATED PARTIES

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

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

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	60.00%	See Attached	1.2	3.00%	Mgmt. Fees	\$ 15,000	17-3	1
2	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.6	1.50%	Alloc. Salary	1,800	17-7	2
3	Joel Meystel	Relative	Administrative	0.00%	See Attached	0.6	3.00%	Alloc. Salary	685	17-7	3
4											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	\$ 17,485		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: 01/01/11 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care

0048496

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 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	686,836	17	\$ 15,204	\$ 20,440	\$ 452	1	
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	686,836	17	25,846	8,238	20,440	769	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	686,836	17	1,829	20,440	54	3	
4	17	ADMINISTRATIVE	AVAIL. BED DAYS	686,836	17	356,736	356,736	20,440	10,616	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	26,635	20,440	793	5	
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	6,564	20,440	195	6	
7	21	CLERICAL & GENERAL	AVAIL. BED DAYS	686,836	17	890,719	835,933	20,440	26,507	7
8	24	SEMINARS	AVAIL. BED DAYS	686,836	17	10,148	20,440	302	8	
9	25	AUTO AND TRAVEL	AVAIL. BED DAYS	686,836	17	29,510	20,440	878	9	
10	26	INSURANCE	AVAIL. BED DAYS	686,836	17	21,145	20,440	629	10	
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	686,836	17	236,117	20,440	7,027	11	
12	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	16,611	20,440	494	12	
13	32	INTEREST	AVAIL. BED DAYS	686,836	17	1,006	20,440	30	13	
14	33	REAL ESTATE TAX	AVAIL. BED DAYS	686,836	17	46,424	20,440	1,382	14	
15	34	RENT	AVAIL. BED DAYS	686,836	17	156,000	20,440	4,643	15	
16	35	AUTO RENTAL	AVAIL. BED DAYS	686,836	17	18,091	20,440	538	16	
17	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	686,836	17	6,400	20,440	190	17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,864,985	\$ 1,200,907	\$ 55,499	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care

0048496

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY	AVAIL. BED DAYS	686,836	17	\$ 132,684	\$ 123,698	20,440	\$ 3,949	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	686,836	17	15,896		20,440	473	2
3	10	NURSING SALARY	AVAIL. BED DAYS	686,836	17	597,577	597,577	20,440	17,784	3
4	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	686,836	17	38,325		20,440	1,141	4
5	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	686,836	17	74,394		20,440	2,214	5
6	17	ADMINISTRATIVE	AVAIL. BED DAYS	686,836	17	195,987	195,987	20,440	5,833	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	51,975		20,440	1,547	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	849		20,440	25	8
9	21	CLERICAL & GENERAL	AVAIL. BED DAYS	686,836	17	107,160	91,547	20,440	3,189	9
10	24	SEMINARS	AVAIL. BED DAYS	686,836	17	3,858		20,440	115	10
11	25	AUTO AND TRAVEL	AVAIL. BED DAYS	686,836	17	5,508		20,440	164	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	686,836	17	30,309		20,440	902	12
13	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	673		20,440	20	13
14	35	AUTO RENTAL	AVAIL. BED DAYS	686,836	17	61,921		20,440	1,843	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		\$ 39,199	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 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 Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	AVAIL. BED DAYS	686,836	17	\$ 5,168	\$ 20,440	\$ 154	1
2	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	686,836	17	624	20,440	19	2
3	21	OFFICE EXPENSE	AVAIL. BED DAYS	686,836	17	1,000	20,440	30	3
4	30	DEPRECIATION	AVAIL. BED DAYS	686,836	17	51,542	20,440	1,534	4
5	32	INTEREST EXPENSE	AVAIL. BED DAYS	686,836	17	55,103	20,440	1,640	5
6	33	REAL ESTATE TAXES	AVAIL. BED DAYS	686,836	17	29,058	20,440	865	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	\$	\$ 4,242	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care

0048496 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care

0048496

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Exceptional Care

0048496

Report Period Beginning:

01/01/11

Ending:

12/31/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1										1									
2										2									
3										3									
4										4									
5	See Supplemental Schedule									5									
Working Capital																			
6	Lake Forest Bank & Trust Co.		X	Line of Credit			500,000			23,682	6								
7	Omnicare		X	Insurance			147,283			11,716	7								
8	See Supplemental Schedule						200,034	225,409		12,905	8								
9	TOTAL Facility Related						\$ 200,034	\$ 872,691		\$ 48,304	9								
B. Non-Facility Related*																			
10	Allocated From YAM Mgmt.	X								30	10								
11	Allocated From 8131 N. Montice	X								1,640	11								
12	Interest Income		X							(97)	12								
13	See Supplemental Schedule										13								
14	TOTAL Non-Facility Related						\$	\$		\$ 1,573	14								
15	TOTALS (line 9+line14)						\$ 200,034	\$ 872,691		\$ 49,877	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Exceptional Care

0048496

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	Tricare Rehab		X	Settlement of Debt			\$ 200,034	\$ 165,409		7.00%	\$ 12,905	8							
9	Shareholders/Partners		X	Working Capital				60,000				9							
10												10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital																		
	B. Non-Facility Related*																		
15							\$	\$			\$	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 2010 report.		\$	101,306		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.)		\$	104,010		2
3. Under or (over) accrual (line 2 minus line 1).		\$	2,704		3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	201,084		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.)		\$	15,070		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.		\$	218,858		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006	120,838			8
	2007	122,802			9
	2008	124,389			10
	2009	100,797			11
	2010	103,145			12
2011 Accrual = \$103,145 + unpaid \$97,938 = \$201,083					
Allocated From 8131 N. Monticello = \$865					
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.

SEE ACCOUNTANTS' COMPILATION REPORT

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Exceptional Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048496

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 Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 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.

Facility Name & ID Number Exceptional Care

0048496

Report Period Beginning:

01/01/11

Ending:

12/31/11

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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2	<u>Allocated From 8131 N. Monticello</u>		<u>2010</u>	<u>2,649</u>	2
3	TOTALS			\$ <u>2,649</u>	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	Various		2007		4,773		20	318	318	1,432	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 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								67	
68			30,779	1,632	1,087	(545)	1,604	68	
69				48,425		(48,425)		69	
70			\$ 35,552	\$ 50,057		\$ 1,405	\$ (48,652)	\$ 3,036	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 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		\$ 271,744	\$ 50,057		\$ 19,390	\$ (30,667)	\$ 55,924	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)	\$ 271,744	\$ 50,057		\$ 19,390	\$ (30,667)	\$ 55,924	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 35,552	\$ 50,057		\$ 1,405	\$ (48,652)	\$ 3,036	1
2	Sherwin Williams Wallpaper	2008	3,484		20			3,484	2
3	Judicial Receivers Wallcovering	2008	10,800		20			10,800	3
4	Ltc Solutions/Econocare - Flooring, Handrails, Window Treatmen	2008	27,945		20	2,794	2,794	10,014	4
5	Seco Refrigeration - Hot Water Heater	2008	5,492		20	458	458	1,487	5
6	Satellite America	2008	3,700		20	370	370	1,172	6
7	Upholstery, Curtains, Bedspreads	2009	19,654		20	3,931	3,931	9,827	7
8	Econocare Handrails, Crashrail, Cornerguards	2009	12,223		20	1,222	1,222	2,547	8
9	Heating Units & Hot Water Valve	2009	2,962		20	148	148	432	9
10	Custom Cabinets, Reception Desk, Wardrobes & Window Treatm	2010	44,111		20	2,942	2,942	4,411	10
11	Ceramic Wall And Tile In Shower Rm, Plumbing Fixtures, Grab H	2010	24,500		20	1,634	1,634	2,450	11
12	Awning Reupholstered	2010	6,425		20	321	321	455	12
13	Corner Guards	2010	2,951		20	197	197	295	13
14	Vct And Cove Base Removal, Custom Pvt And Millwork Base	2010	18,886		20	1,260	1,260	1,889	14
15	Therapy Rm - Basebaord, Cove Base And Vct Removal, Tile, Mill	2010	7,909		20	528	528	791	15
16	Cove Base Take Up & Installation Of Millwork Base, Window Tre	2010	2,795		20	186	186	280	16
17	Medication/Therapy Rms - Cabinets, Countertop	2010	9,091		20	606	606	909	17
18	Heating Duct Furnace	2010	7,778		20	519	519	778	18
19	Patio And Driveway	2011	4,500		20	169	169	169	19
20	6" Water Service System	2011	20,985		20	700	700	700	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)		\$ 271,744	\$ 50,057		\$ 19,390	\$ (30,667)	\$ 55,924	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		\$ 271,744	\$ 50,057		\$ 19,390	\$ (30,667)	\$ 55,924	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)	\$ 271,744	\$ 50,057		\$ 19,390	\$ (30,667)	\$ 55,924	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		\$ 271,744	\$ 50,057		\$ 19,390	\$ (30,667)	\$ 55,924
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 (lines 1 thru 33)	\$ 271,744	\$ 50,057		\$ 19,390	\$ (30,667)	\$ 55,924

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		\$	\$		\$	\$	\$	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. Monticell	2010	20,580	612	39	528	(84)	770	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From YAM Management, LLC	2010	980	98	20	98		125	9
10									10
11	Allocated From 8131 N. Monticell	2010	9,219	922	20	461	(461)	709	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1								1	
2								2	
3								3	
4								4	
5								5	
6								6	
7								7	
8								8	
9								9	
10								10	
11								11	
12								12	
13								13	
14								14	
15								15	
16								16	
17								17	
18								18	
19								19	
20								20	
21								21	
22								22	
23								23	
24								24	
25								25	
26								26	
27								27	
28								28	
29								29	
30								30	
31								31	
32								32	
33								33	
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 30,779	\$ 1,632		\$ 1,087	\$ (545)	\$ 1,604	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	\$ 76,685	\$ 324	\$ 12,773	\$ 12,449	10	\$ 51,973	71
72	Current Year Purchases	79	3		(3)	10	3	72
73	Fully Depreciated Assets	28,412				10	28,412	73
74								74
75	TOTALS	\$ 105,177	\$ 327	\$ 12,773	\$ 12,446		\$ 80,388	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		Allocated From YAM Mgmt	2009	\$ 800	\$ 89	\$ 89	\$	5	\$ 30	76
77										77
78										78
79										79
80	TOTALS			\$ 800	\$ 89	\$ 89	\$		\$ 30	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)	\$ 380,370	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 50,473	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 32,252	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (18,221)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 136,343	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		\$ 232,200			3
4	Additions							4
5								5
6								6
7	TOTAL		56		\$ 232,200			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: \$ 1,229 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		\$	538	17
18	Allocated From YAM Consulting			1,843	18
19					19
20					20
21	TOTAL		\$	2,381	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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	107,394	\$		\$	107,394	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				54,860				54,860	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				79,741				79,741	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescripts					95,555			95,555	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): _____											12
13	Other (specify): <u>See Supplemental</u>							4,102			4,102	13
14	TOTAL			\$		\$	241,995	\$	99,657	\$	341,652	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care# 0048496Report Period Beginning: 01/01/11Ending: 12/31/11**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/11

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	727,492		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	78,903		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,587		8
9	Other(specify): <u>See Attached Schedule</u>	244,278		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,052,260	\$	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	236,512		15
16	Equipment, at Historical Cost	164,711		16
17	Accumulated Depreciation (book methods)	(161,593)		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>	128,100		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 367,730	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,419,990	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,649,318	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	987		28
29	Short-Term Notes Payable	688,422		29
30	Accrued Salaries Payable	51,038		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,656		31
32	Accrued Real Estate Taxes(Sch.IX-B)	201,084		32
33	Accrued Interest Payable	1,938		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	787,554		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,397,997	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	184,269		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)	\$ 184,269	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,582,266	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,162,276)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,419,990	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (931,667)	1
2	Restatements (describe):		2
3	Adjustment	135,422	3
4			4
5	Liability from Medicare Audit	(1,406,530)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,202,775)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	67,999	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	(27,500)	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)	\$ 40,499	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)	\$ (2,162,276)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care# 0048496Report Period Beginning: 01/01/11Ending: 12/31/11

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	\$ 2,897,675	1
2	Discounts and Allowances for all Levels	63,308	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,960,983	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	691,017	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 691,017	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	85,515	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,835	19
20	Radiology and X-Ray	985	20
21	Other Medical Services	1,813	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 97,148	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	97	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 97	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	1,441	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,441	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,750,686	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	579,396	31
32	Health Care	1,067,524	32
33	General Administration	1,046,397	33
B. Capital Expense			
34	Ownership	444,975	34
C. Ancillary Expense			
35	Special Cost Centers	513,735	35
36	Provider Participation Fee	30,660	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,682,687	40
41	Income before Income Taxes (line 30 minus line 40)**	67,999	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 67,999	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:

01/01/11

Ending:

12/31/11

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,981	2,222	\$ 90,648	\$ 40.80	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,370	2,706	84,148	31.10	3
4	Licensed Practical Nurses	9,919	10,717	278,741	26.01	4
5	CNAs & Orderlies	27,900	30,220	334,802	11.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,925	4,207	36,868	8.76	10
11	Social Service Workers	1,946	2,086	30,243	14.50	11
12	Dietician					12
13	Food Service Supervisor	1,893	2,086	35,163	16.86	13
14	Head Cook	4,811	5,324	69,208	13.00	14
15	Cook Helpers/Assistants	3,350	3,732	30,335	8.13	15
16	Dishwashers					16
17	Maintenance Workers	2,109	2,291	39,507	17.24	17
18	Housekeepers	7,748	8,346	81,446	9.76	18
19	Laundry	1,449	1,635	14,863	9.09	19
20	Administrator	2,076	2,166	78,634	36.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,157	4,483	46,327	10.33	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	1,635	1,811	57,010	31.48	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	77,269	84,032	\$ 1,307,943 *	\$ 15.56	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	370	\$ 15,483	01-03	35
36	Medical Director	Monthly	26,000	09-03	36
37	Medical Records Consultant	Monthly	983	10-03	37
38	Nurse Consultant	1,550	78,198	10-03	38
39	Pharmacist Consultant	35	2,656	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	24	1,200	11-03	44
45	Social Service Consultant	63	3,180	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,042	\$ 127,700		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%	\$ 78,634	Workers' Compensation Insurance	\$ 40,394	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	54,521	Advertising: Employee Recruitment	640	
				FICA Taxes	101,163	Health Care Worker Background Check		
				Employee Health Insurance	46,363	(Indicate # of checks performed <u>81</u>)	810	
				Employee Meals	13,478	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	7,302	
				Pension Plan Contribution	11,254	Licenses & Permits	2,287	
				Other Employee Benefits	2,266	Advertising & Promotion	820	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						See Supplemental Schedule	239	
						Less: Public Relations Expense	()	
						Non-allowable advertising	(820)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 13,268	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description			Description	
Amount				Line #			Amount	
Management Fees - Yosef Meystel							Out-of-State Travel	
\$ 15,000							\$	
YAM Consulting - Director of Operations Consultant								
11,598							In-State Travel	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL			Seminar Expense	
\$ 26,598				\$			850	
							Allocated From YAM Management	
							302	
							Allocated From YAM Consulting	
							115	
							Entertainment Expense	
							()	
							TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 1,267	

* 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:

01/01/11

Ending:

12/31/11

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 \$6,384
- (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. \$ 7,471 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? X YES NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 30,660
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. \$ 13,478 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.

SEE ACCOUNTANTS' COMPILATION REPORT