FOR BHF USE

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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

I. IDPH License ID Number: 0048496

Facility Name: Exceptional Care

Address: 5701 W 79th Street (Number) Burbank (City) 60459 (Zip Code)

County: Cook

Telephone Number: (708) 499-5400 **Fax #** (708) 499-5571

HFS ID Number:

Date of Initial License for Current Owners: 10/1/2006

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/13 to 12/31/13 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Cary C. Buxbaum, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	56	Skilled (SNF)	56	20,440	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	56	TOTALS	56	20,440	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,696	1,967	4,670	19,333	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,696	1,967	4,670	19,333	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.58%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 10/01/2006 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 56 and days of care provided 4,083

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	150,715	10,560	14,680	175,955		175,955	(10,485)	165,470			1
2	Food Purchase		97,163		97,163		97,163	(99)	97,064			2
3	Housekeeping	96,161	9,518		105,679		105,679		105,679			3
4	Laundry	33,592	5,901		39,493		39,493		39,493			4
5	Heat and Other Utilities			93,165	93,165		93,165	(5,027)	88,138			5
6	Maintenance	36,692	26,297	58,186	121,175		121,175	3,976	125,151			6
7	Other (specify):*							754	754			7
8	TOTAL General Services	317,160	149,439	166,031	632,630		632,630	(10,881)	621,749			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	927,490	57,950	67,876	1,053,316		1,053,316	(48,592)	1,004,724			10
10a	Therapy		445		445		445		445			10a
11	Activities	55,438	4,174	961	60,573		60,573		60,573			11
12	Social Services	32,492		2,341	34,833		34,833		34,833			12
13	CNA Training											13
14	Program Transportation			3,614	3,614		3,614	997	4,611			14
15	Other (specify):*							2,251	2,251			15
16	TOTAL Health Care and Programs	1,015,420	62,569	98,792	1,176,781		1,176,781	(45,344)	1,131,437			16
	C. General Administration											
17	Administrative	142,882		35,577	178,459		178,459	639	179,098			17
18	Directors Fees											18
19	Professional Services			175,737	175,737		175,737	(108,345)	67,392			19
20	Dues, Fees, Subscriptions & Promotions			28,235	28,235		28,235	(12,283)	15,952			20
21	Clerical & General Office Expenses	37,543		114,655	152,198		152,198	(51,682)	100,516			21
22	Employee Benefits & Payroll Taxes			350,081	350,081		350,081		350,081			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,440	2,440		2,440	335	2,775			24
25	Other Admin. Staff Transportation			3,133	3,133		3,133	1,876	5,009			25
26	Insurance-Prop.Liab.Malpractice			251,768	251,768		251,768	624	252,392			26
27	Other (specify):*							10,767	10,767			27
28	TOTAL General Administration	180,425		961,626	1,142,051		1,142,051	(158,069)	983,982			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,513,005	212,008	1,226,449	2,951,462		2,951,462	(214,294)	2,737,168			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: 01/01/13 Ending: 12/31/13

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			56,835	56,835		56,835	41,627	98,462			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			88,254	88,254		88,254	35,332	123,586			32
33	Real Estate Taxes			67,443	67,443		67,443	61,974	129,417			33
34	Rent-Facility & Grounds			350,400	350,400		350,400	(219,000)	131,400			34
35	Rent-Equipment & Vehicles			1,306	1,306		1,306	1,616	2,922			35
36	Other (specify):*			12,362	12,362		12,362	(12,362)				36
37	**TOTAL Ownership**			576,600	576,600		576,600	(90,813)	485,787			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		101,583	478,332	579,915		579,915	(58,487)	521,428			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			97,929	97,929		97,929		97,929			42
43	Other (specify):*			187,336	187,336		187,336	(187,336)				43
44	**TOTAL Special Cost Centers**		101,583	763,597	865,180		865,180	(245,823)	619,357			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,513,005	313,591	2,566,646	4,393,242		4,393,242	(550,930)	3,842,312			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: 01/01/13 Ending: 12/31/13

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(5,421)	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	(4,602)	30		9
10	Interest and Other Investment Income	(98)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(99)	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				18
19	Entertainment	(5,324)	21		19
20	Contributions	(11,625)	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	(82,444)	21		24
25	Fund Raising, Advertising and Promotional	(5,308)	43		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	(250,390)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (365,311)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(185,619)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (185,619)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (550,930)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Exceptional Care

ID# 0048496

Report Period Beginning: 01/01/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Additional R&M	$ 14,215	06	1
2	Amortization of Loan Costs	(12,362)	36	2
3	Jury Duty Income	(17)	21	3
4	Miscellaneous Income	(29)	21	4
5	Non-Allowable Fees	(176,028)	43	5
6	Non Allowable Legal	(5,000)	19	6
7	Theft Loss	(230)	21	7
8	Non Allowable Interest	(50,354)	32	8
9	COPE Dues	(1,791)	20	9
10				10
11	Building Co- Amortization	(5,765)	31	11
12	Building Co- Bank Charges	(436)	21	12
13	Building Co- Bookeeping Fee	(12,000)	21	13
14	Building Co- Licenses & Fees	(250)	21	14
15	Building Co- Professional Fees	(343)	19	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(250,390)		49

Exceptional Care

ID# 0048496

Report Period Beginning: 01/01/13

Ending: 12/31/13

	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	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Exceptional Care # 0048496 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary				(10,485)								(10,485)	1
2	Food Purchase	(99)											(99)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(5,421)		394									(5,027)	5
6	Maintenance	14,215		690	(10,929)								3,976	6
7	Other (specify):*			59	695								754	7
8	**TOTAL General Services**	8,695		1,143	(20,719)								(10,881)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				(48,592)								(48,592)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation				997								997	14
15	Other (specify):*				2,251								2,251	15
16	**TOTAL Health Care and Programs**				(45,344)								(45,344)	16
	C. General Administration													
17	Administrative			9,346	(8,707)								639	17
18	Directors Fees													18
19	Professional Services	(5,343)	343	(91,348)	(10,858)	117	(1,256)						(108,345)	19
20	Fees, Subscriptions & Promotions	(13,416)		262	865	6							(12,283)	20
21	Clerical & General Office Expenses	(100,730)	12,686	29,453	6,858	51							(51,682)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			108	227								335	24
25	Other Admin. Staff Transportation			1,008	868								1,876	25
26	Insurance-Prop.Liab.Malpractice			518	106								624	26
27	Other (specify):*			7,880	2,887								10,767	27
28	**TOTAL General Administration**	(119,489)	13,029	(42,773)	(7,754)	174	(1,256)						(158,069)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(110,794)	13,029	(41,630)	(73,817)	174	(1,256)						(214,294)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Exceptional Care # 0048496 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(4,602)	44,279	632		1,318							41,627	30
31	Amortization of Pre-Op. & Org.	(5,765)	5,765											31
32	Interest	(50,452)	84,031	520		1,233							35,332	32
33	Real Estate Taxes		60,418			1,556							61,974	33
34	Rent-Facility & Grounds		(207,000)	(7,436)		(4,564)							(219,000)	34
35	Rent-Equipment & Vehicles			679	937								1,616	35
36	Other (specify):*	(12,362)											(12,362)	36
37	**TOTAL Ownership**	(73,181)	(12,507)	(5,605)	937	(457)							(90,813)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(58,487)					(58,487)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(181,336)			(6,000)								(187,336)	43
44	**TOTAL Special Cost Centers**	(181,336)			(6,000)			(58,487)					(245,823)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(365,311)	522	(47,235)	(78,880)	(283)	(1,256)	(58,487)					(550,930)	45

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 207,000	Exceptional NRC Realty	100.00%	$	$ (207,000)	1
2	V	31	Amortization Expense		Exceptional NRC Realty	100.00%	5,765	5,765	2
3	V	21	Bank Charges		Exceptional NRC Realty	100.00%	436	436	3
4	V	21	Bookeeping Fee		Exceptional NRC Realty	100.00%	12,000	12,000	4
5	V	30	Depreciation		Exceptional NRC Realty	100.00%	44,279	44,279	5
6	V	21	Licenses & Fees		Exceptional NRC Realty	100.00%	250	250	6
7	V	32	Interest Expense	20	Exceptional NRC Realty	100.00%	84,051	84,031	7
8	V	19	Professional Fees		Exceptional NRC Realty	100.00%	343	343	8
9	V	33	Real Estate Taxes	28,303	Exceptional NRC Realty	100.00%	88,721	60,418	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 235,323			$ 235,845	$ * 522	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	YAM MANAGEMENT, LLC	100.00%	$ 394	$ 394	15
16	V	6	REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	690	690	16
17	V	7	EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	59	59	17
18	V	17	ADMINISTRATIVE		YAM MANAGEMENT, LLC	100.00%	9,346	9,346	18
19	V	19	PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	1,687	1,687	19
20	V	20	FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	262	262	20
21	V	21	CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	29,453	29,453	21
22	V	24	SEMINARS		YAM MANAGEMENT, LLC	100.00%	108	108	22
23	V	25	AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	1,008	1,008	23
24	V	26	INSURANCE		YAM MANAGEMENT, LLC	100.00%	518	518	24
25	V	27	EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	7,880	7,880	25
26	V	30	DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	632	632	26
27	V	32	INTEREST		YAM MANAGEMENT, LLC	100.00%	520	520	27
28	V	33	REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%			28
29	V	34	RENT		YAM MANAGEMENT, LLC	100.00%	4,564	4,564	29
30	V	35	AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	679	679	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V	19	BOOKKEEPING FEES	57,035	YAM MANAGEMENT, LLC	100.00%		(57,035)	35
36	V	19	ACCOUNTING	36,000	YAM MANAGEMENT, LLC	100.00%		(36,000)	36
37	V	34	RENT	12,000	YAM MANAGEMENT, LLC	100.00%		(12,000)	37
38	V								38
39	Total			$ 105,035			$ 57,800	$ * (47,235)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	YAM CONSULTING, LLC	100.00%	$ 4,195	$ 4,195	15
16	V	7	EMP. BEN. GEN. SERV.		YAM CONSULTING, LLC	100.00%	695	695	16
17	V	10	NURSING SALARY		YAM CONSULTING, LLC	100.00%	16,208	16,208	17
18	V	14	PROGRAM TRANSPORTATION		YAM CONSULTING, LLC	100.00%	997	997	18
19	V	15	EMP. BEN. HEALTHCARE		YAM CONSULTING, LLC	100.00%	2,251	2,251	19
20	V	17	ADMINISTRATIVE		YAM CONSULTING, LLC	100.00%	8,993	8,993	20
21	V	19	PROFESSIONAL FEES		YAM CONSULTING, LLC	100.00%	487	487	21
22	V	20	FEES, SUBSCRIPTIONS		YAM CONSULTING, LLC	100.00%	865	865	22
23	V	21	CLERICAL & GENERAL		YAM CONSULTING, LLC	100.00%	6,858	6,858	23
24	V	24	SEMINARS		YAM CONSULTING, LLC	100.00%	227	227	24
25	V	25	AUTO AND TRAVEL		YAM CONSULTING, LLC	100.00%	868	868	25
26	V	27	EMP. BEN.-GEN. ADMIN.		YAM CONSULTING, LLC	100.00%	2,887	2,887	26
27	V	26	INSURANCE		YAM CONSULTING, LLC	100.00%	106	106	27
28	V	35	AUTO RENTAL		YAM CONSULTING, LLC	100.00%	937	937	28
29	V	6	REPAIRS AND MAINTENANCE SALARY		YAM CONSULTING, LLC	100.00%	1,841	1,841	29
30	V								30
31	V								31
32	V	06	PAINTER	7,520	YAM CONSULTING, LLC	100.00%		(7,520)	32
33	V	01	DIETICIAN CONSULTING	14,680	YAM CONSULTING, LLC	100.00%		(14,680)	33
34	V	10	NURSE CONSULTING	64,800	YAM CONSULTING, LLC	100.00%		(64,800)	34
35	V	17	DIR. OF OPERATIONS CONSULT	17,700	YAM CONSULTING, LLC	100.00%		(17,700)	35
36	V	19	DATA PROCESSING FEES	11,345	YAM CONSULTING, LLC	100.00%		(11,345)	36
37	V	43	MARKETING	6,000	YAM CONSULTING, LLC	100.00%		(6,000)	37
38	V	06	PROJECT MANAGER INCOME	5,250	YAM CONSULTING, LLC	100.00%		(5,250)	38
39	Total			$ 127,295			$ 48,415	$ * (78,880)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	8131 N. MONTICELLO, LLC	100.00%	$ 117	$ 117	15
16	V	20	DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		6	6	16
17	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		51	51	17
18	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		1,318	1,318	18
19	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		1,233	1,233	19
20	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		1,556	1,556	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	4,564	8131 N. MONTICELLO, LLC			(4,564)	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			$ 4,564			$ 4,281	$ * (283)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Payroll Services	$ 9,664	ProPay HR LLC	66.67%	$ 8,408	$ (1,256)	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			$ 9,664			$ 8,408	$ * (1,256)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy Services	$ 365,541	Renewal Rehab	100.00%	$ 307,054	$ (58,487)	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			$ 365,541			$ 307,054	$ * (58,487)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	EXCEPTIONAL NRC REALTY	SKOKIE	BUILDING CO.	1
2	257 LIMITED PARTNERSHIP	19.000%	CONCORD NURSING AND REHABILITATION CENTER,LLC	OAK LAWN	YAM MANAGEMENT	SKOKIE	MANAGEMENT CO.	2
3	350 LIMITED PARTNERSHIP	1.000%	DOLTON NURSING & REHAB,LLC	DOLTON	YAM CONSULTING	SKOKIE	CONSULTING CO.	3
4	42170 LIMITED PARTNERSHIP	10.000%	EVANSTON NURSING & REHAB CENTER	EVANSTON	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	4
5	YOSEF MEYSTEL	60.000%	HIGHLAND PARK NURSING AND REHAB CENTER, LLC	HIGHWOOD	PROPAY	EVANSTON	PAYROLL SERVICES	5
6			INTERNATIONAL NURSING & REHAB CENTER,LLC	CHICAGO	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	6
7			LITCHFIELD CARE CENTER,LLC	LITCHFIELD	ROOSEVELT RISK MANAGEME	SKOKIE	CAPTIVE INSURANCE	7
8			NORTH CHURCH NURSING & REHAB,LLC	JACKSONVILLE				8
9			PLAZA NURSING AND REHAB CENTER,LLC	MIDLOTHIAN				9
10			PLUM GROVE NURSING AND REHAB,LLC	PALATINE				10
11			RIVIERA CARE CENTER,LLC	CHICAGO HEIGHTS				11
12			SPRINGFIELD CARE CENTER,LLC	SPRINGFIELD				12
13			THE ARBORS AT MICHIGAN CITY	MICHIGAN CITY,IN				13
14			THE COPPERAS HOLLOW	CALDWELL, TX				14
15			ISLAND CITY REHAB CENTER	WILMINGTON				15
16			LINCOLN REHAB	DECATUR				16
17			RIVERWOOD REHAB	EAST MOLINE				17
18			RIVER CROSSING REHAB	GALESBURG				18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Owner	Administrative	60.00%	See Attached	1	2.50%	Mgmt. Fees	$ 17,877	17-03	1
2	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.5	1.25%	Alloc. Salary	1,530	17-07	2
3	Joel Meystel	Relative	Administrative	0.00%	See Attached	0.5	1.25%	Alloc. Salary	628	17-07	3
4	Cynthia Meystel	Relative	Clerical	0.00%	See Attached	0.1	3.03%	Alloc. Salary	461	21-7	4
5	Shimon Meystel	Relative	Clerical	0.00%	See Attached	1	2.50%	Alloc. Salary	217	21-7	5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 20,713		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: 01/01/13 Ending: 12/31/13

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
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: 01/01/13 Ending: 12/31/13

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. BED DAYS	806,222	20	$ 15,532	$	20,440	$ 394	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	806,222	20	27,235	10,706	20,440	690	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	806,222	20	2,325		20,440	59	3
4	17	ADMINISTRATIVE	AVAIL. BED DAYS	806,222	20	368,628	368,628	20,440	9,346	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	806,222	20	66,554		20,440	1,687	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	806,222	20	10,341		20,440	262	6
7	21	CLERICAL & GENERAL	AVAIL. BED DAYS	806,222	20	1,161,730	1,062,779	20,440	29,453	7
8	24	SEMINARS	AVAIL. BED DAYS	806,222	20	4,271		20,440	108	8
9	25	AUTO AND TRAVEL	AVAIL. BED DAYS	806,222	20	39,751		20,440	1,008	9
10	26	INSURANCE	AVAIL. BED DAYS	806,222	20	20,417		20,440	518	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	806,222	20	310,817		20,440	7,880	11
12	30	DEPRECIATION	AVAIL. BED DAYS	806,222	20	24,916		20,440	632	12
13	32	INTEREST	AVAIL. BED DAYS	806,222	20	20,530		20,440	520	13
14	33	REAL ESTATE TAX	AVAIL. BED DAYS	806,222	20	-		20,440		14
15	34	RENT	AVAIL. BED DAYS	806,222	20	180,000		20,440	4,564	15
16	35	AUTO RENTAL	AVAIL. BED DAYS	806,222	20	26,797		20,440	679	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,279,844	$ 1,442,113		$ 57,800	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	AVAIL. BED DAYS	806,222	20	$ 165,484	$ 152,992	20,440	$ 4,195	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	806,222	20	27,395		20,440	695	2
3	10	NURSING SALARY	AVAIL. BED DAYS	806,222	20	639,288	639,288	20,440	16,208	3
4	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	806,222	20	39,307		20,440	997	4
5	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	806,222	20	88,801		20,440	2,251	5
6	17	ADMINISTRATIVE	AVAIL. BED DAYS	806,222	20	354,711	354,711	20,440	8,993	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	806,222	20	19,212		20,440	487	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	806,222	20	34,122		20,440	865	8
9	21	CLERICAL & GENERAL	AVAIL. BED DAYS	806,222	20	270,517	258,772	20,440	6,858	9
10	24	SEMINARS	AVAIL. BED DAYS	806,222	20	8,935		20,440	227	10
11	25	AUTO AND TRAVEL	AVAIL. BED DAYS	806,222	20	34,250		20,440	868	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	806,222	20	113,873		20,440	2,887	12
13	26	INSURANCE	AVAIL. BED DAYS	806,222	20	4,192		20,440	106	13
14	35	AUTO RENTAL	AVAIL. BED DAYS	806,222	20	36,968		20,440	937	14
15	6	REPAIRS AND MAINTENANCE	AVAIL. BED DAYS	806,222	20	72,622	72,622	20,440	1,841	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,909,677	$ 1,478,385		$ 48,415	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	AVAIL. BED DAYS	806,222	20	$ 4,605	$	20,440	$ 117	1
2	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	806,222	20	250		20,440	6	2
3	21	OFFICE EXPENSE	AVAIL. BED DAYS	806,222	20	2,000		20,440	51	3
4	30	DEPRECIATION	AVAIL. BED DAYS	806,222	20	51,991		20,440	1,318	4
5	32	INTEREST EXPENSE	AVAIL. BED DAYS	806,222	20	48,653		20,440	1,233	5
6	33	REAL ESTATE TAXES	AVAIL. BED DAYS	806,222	20	61,377		20,440	1,556	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					$ 168,876	$		$ 4,281	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [X] NO [ ]

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

Name of Related Organization: ProPay HR LLC
Street Address: 2201 W MAIN STREET
City / State / Zip Code: EVANSTON, ILLINOIS 60202
Phone Number: (847) 905-3268
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Payorll Services	Direct			$	$		$ 8,408	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					$	$		$ 8,408	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Renewal Rehab	Direct			$	$		$ 307,054	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					$	$		$ 307,054	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
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: 01/01/13 Ending: 12/31/13

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
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: 01/01/13 Ending: 12/31/13

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
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: 01/01/13 Ending: 12/31/13

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
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: 01/01/13 Ending: 12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Banco Popular		X	Mortgage Payable			$	$ 3,015,000			$ 84,051	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		X	Line of Credit				805,000				6
7	Omnicare		X	Insurance							3,893	7
8	See Supplemental Schedule							30,775			35,760	8
9	TOTAL Facility Related						$	$ 3,850,775			$ 123,704	9
	B. Non-Facility Related*											
10	Building Co. Interest Income										(98)	10
11	Interest Income										(20)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (118)	14
15	TOTALS (line 9+line14)						$	$ 3,850,775			$ 123,586	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: 01/01/13 Ending: 12/31/13

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Tricare Rehab		X	Settlement of Debt			$	$			$ 3,326	8
9	Bank Financial		X	Commercial Loan				30,775			30,681	9
10	Allocated from YAM Management										520	10
11	Allocated from 8131 N. Monticello										1,233	11
12												12
13												13
14	TOTAL Working Capital							30,775			35,760	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 113,809	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.)		$ 122,391	2
3. Under or (over) accrual (line 2 minus line 1).		$ 8,582	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 120,835	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 129,417	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	124,389	8
	2009	100,797	9
	2010	103,145	10
	2011	113,809	11
	2012	120,835	12

2013 Accrual = 2012 tax
Beginning Accrual adjusted to reflect the PY unpaid taxes that were paid
Allocated from 8131 N. Monticello- $1,556

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2012	$	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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Exceptional Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048496

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-32-204-006-0000	Long Term Care Property	$ 5,125.81	$ 5,125.81
2.	19-32-205-023-0000	Long Term Care Property	$ 115,709.07	$ 115,709.07
3.	10-23-325-045-0000	Management Company	$ 70,066.20	$ 1,556.08
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 190,901.08	$ 122,390.96

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Exceptional Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048496

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236 - 1111 FAX #: (847) 236 - 1155

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

Enter the tax index number and real estate tax assessed for 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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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: 01/01/13 Ending: 12/31/13

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 [X] (b) Rent from a Related Organization. [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2013	$ 239,130	1
2	Allocated from 8131 Monticello		2010	2,256	2
3	TOTALS			$ 241,386	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	56		2013	1972	$ 817,826	$ 11,359	39	$ 20,970	$ 9,611	$ 20,970	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2007	4,773		20	318	318	2,069	9
10	Various			2008	51,421		20	3,622	3,622	34,201	10
11	Various			2009	34,839		20	5,301	5,301	23,408	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

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		28,207	1,441		1,035	(406)	3,343	68
69	Financial Statement Depreciation			56,835			(56,835)		69
70	TOTAL (lines 4 thru 69)		$ 937,066	$ 69,635		$ 31,247	$ (38,388)	$ 83,991	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 937,066	$ 69,635		$ 31,247	$ (38,388)	$ 83,991	1
2	Custom Cabinets, Reception Desk, Wardrobes & Window Treatme	2010	44,111		20	2,942	2,942	10,296	2
3	Ceramic Wall And Tile In Shower Rm, Plumbing Fixtures, Grab B	2010	24,500		20	1,634	1,634	5,718	3
4	Awning Reupholstered	2010	6,425		20	321	321	1,098	4
5	Corner Guards	2010	2,951		20	197	197	689	5
6	Vct And Cove Base Removal, Custom Pvt And Millwork Base	2010	18,886		20	1,260	1,260	4,408	6
7	Therapy Rm - Basebaord, Cove Base And Vct Removal, Tile, Millv	2010	7,909		20	528	528	1,846	7
8	Cove Base Take Up & Installation Of Millwork Base, Window Tre	2010	2,795		20	186	186	652	8
9	Medication/Therapy Rms - Cabinets, Countertop	2010	9,091		20	606	606	2,122	9
10	Heating Duct Furnace	2010	7,778		20	519	519	1,815	10
11	Patio And Driveway	2011	4,500		20	300	300	825	11
12	6" Water Service System	2011	20,985		20	1,049	1,049	2,798	12
13	Corridor Lights	2012	22,883		20	1,334	1,334	2,288	13
14	Electrical Work-Wiring Done For The Afp200 Fire Alarm System	2012	3,980		20	232	232	398	14
15	Fire Protection Coverage Per Nfpa & Village Of Burbank Code	2012	103,924		20	7,794	7,794	10,392	15
16	Framing To Enclose Sprinkler Heads	2012	49,850		20	4,571	4,571	4,985	16
17	Boiler Room Plumbing Work	2012	4,500		20	225	225	244	17
18	Dining Room Remodel - Acoustical Ceiling, Cabinetry, Wallcoveri	2012	37,081		20	1,854	1,854	3,708	18
19	Installation Of Ap-Tac Units, Sleeves And Outlets	2013	23,140		20	771	771	771	19
20	Elevator Work- 2 New Car Gates, 1 New Complete Cab	2013	8,460		20	176	176	176	20
21	Sprinkler System	2013	7,315		20	244	244	244	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)		$ 1,348,130	$ 69,635		$ 57,990	$ (11,645)	$ 139,464	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,348,130	$ 69,635		$ 57,990	$ (11,645)	$ 139,464	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)		$ 1,348,130	$ 69,635		$ 57,990	$ (11,645)	$ 139,464	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,348,130	$ 69,635		$ 57,990	$ (11,645)	$ 139,464	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
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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)		$ 1,348,130	$ 69,635		$ 57,990	$ (11,645)	$ 139,464	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 1,348,130	$ 69,635		$ 57,990	$ (11,645)	$ 139,464	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)		$ 1,348,130	$ 69,635		$ 57,990	$ (11,645)	$ 139,464	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 8131 N. Monticello	2010	17,532	521	35	450	(71)	1,555	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from YAM Management	2010	835	84	20	84		273	9
10	Allocated from YAM Management	2012	527	35	20	35		53	10
11	Allocated from YAM Management	2013	94	5	20	5		5	11
12	Allocated from 8131 N. Monticello	2010	7,853	785	20	393	(392)	1,389	12
13	Allocated from 8131 N. Monticello	2013	1,366	11	20	68	57	68	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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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)		$ 28,207	$ 1,441		$ 1,035	$ (406)	$ 3,343	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 126,384	$ 265	$ 8,945	$ 8,680	10	$ 100,098	71
72	Current Year Purchases	311,798	32,979	31,342	(1,637)	10	31,342	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 438,182	$ 33,244	$ 40,287	$ 7,043		$ 131,440	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 Manageme	2011	$ 862	$ 184	$ 184	$	5	$ 433	76
77										77
78										78
79										79
80	TOTALS			$ 862	$ 184	$ 184	$		$ 433	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,028,560	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 103,063	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 98,461	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (4,602)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 271,337	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.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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. [X] 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		$ 131,400			3
4	Additions							4
5								5
6								6
7	TOTAL		56		$ 131,400 **			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: *

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.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 1,306 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 Consulting		$	$ 937	17
18	Allocated from YAM Management			679	18
19					19
20					20
21	TOTAL		$	$ 1,616	21

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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: 01/01/13 Ending: 12/31/13

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 212,096	$		$ 212,096	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			40,396			40,396	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			209,603			209,603	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				101,318		101,318	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					16,237	265		16,502	13
14	TOTAL			$		$ 478,332	$ 101,583		$ 579,915	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

STATE OF ILLINOIS

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/13 (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	$ 1,320	$ 305,039	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,069,448	1,069,448	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	168,212	168,212	6
7	Other Prepaid Expenses	2,714	2,714	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	22,610	22,610	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,264,304	$ 1,568,023	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		239,130	13
14	Buildings, at Historical Cost		817,826	14
15	Leasehold Improvements, at Historical Cost	509,010	509,010	15
16	Equipment, at Historical Cost	220,519	502,693	16
17	Accumulated Depreciation (book methods)	(258,571)	(302,850)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(5,765)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	1,075,252	1,109,844	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,546,210	$ 2,869,888	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,810,514	$ 4,437,911	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 577,993	$ 587,993	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	57,014	57,014	28
29	Short-Term Notes Payable	835,775	835,775	29
30	Accrued Salaries Payable	69,380	69,380	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,150	2,150	31
32	Accrued Real Estate Taxes(Sch.IX-B)		120,835	32
33	Accrued Interest Payable	3,508	17,294	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	23,254	23,254	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,569,074	$ 1,713,695	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,015,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	2,305,202	370,000	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,305,202	$ 3,385,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,874,276	$ 5,098,695	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,063,762)	$ (660,784)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,810,514	$ 4,437,911	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,419,598)	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,419,599)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	157,401	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	280,936	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(82,500)	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)**	$ 355,837	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,063,762)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,173,561	1
2	Discounts and Allowances for all Levels	(1,135,296)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,038,265	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,396,428	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,396,428	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	95,314	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,776	19
20	Radiology and X-Ray	3,837	20
21	Other Medical Services	8,879	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 115,806	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	98	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 98	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	46	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 46	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,550,643	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	632,630	31
32	Health Care	1,176,781	32
33	General Administration	1,142,051	33
	B. Capital Expense		
34	Ownership	576,600	34
	C. Ancillary Expense		
35	Special Cost Centers	767,251	35
36	Provider Participation Fee	97,929	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,393,242	40
41	**Income before Income Taxes (line 30 minus line 40)****	157,401	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 157,401	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,935,248	44
45	Private Pay - Net Inpatient Revenue	335,204	45
46	Medicare - Net Inpatient Revenue	688,217	46
47	Other-(specify) Insurance	79,596	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,038,265	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care # 0048496 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,016	2,460	$ 107,861	$ 43.85	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,952	4,314	143,545	33.27	3
4	Licensed Practical Nurses	11,153	12,341	320,397	25.96	4
5	CNAs & Orderlies	30,917	33,976	355,687	10.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	744	760	12,325	16.22	9
10	Activity Assistants	4,382	4,688	43,113	9.20	10
11	Social Service Workers	1,832	2,057	32,492	15.80	11
12	Dietician					12
13	Food Service Supervisor	1,912	2,160	36,764	17.02	13
14	Head Cook	5,762	6,333	76,274	12.04	14
15	Cook Helpers/Assistants	3,592	3,856	37,677	9.77	15
16	Dishwashers					16
17	Maintenance Workers	1,992	2,160	36,692	16.99	17
18	Housekeepers	8,873	9,686	96,161	9.93	18
19	Laundry	3,217	3,511	33,592	9.57	19
20	Administrator	2,104	2,320	105,274	45.38	20
21	Assistant Administrator	1,376	1,464	37,608	25.69	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,877	4,061	37,543	9.24	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	87,701	96,147	$ 1,513,005 *	$ 15.74	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	267	$ 14,680	01-03	35
36	Medical Director	Monthly	24,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	864	64,800	10-03	38
39	Pharmacist Consultant	Monthly	3,076	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	16	961	11-03	44
45	Social Service Consultant	38	2,341	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,185	$ 109,858		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Akeem Abiola	Administrator	0.00%	$ 105,274
Moshe Weinberger	Asst Admin	0.00%	37,608
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 142,882

B. Administrative - Other

Description	Amount
Management Fees- Yosef Meystel	$ 17,877
Administrative Consultant- YAM Consulting	17,700
TOTAL (agree to Schedule V, line 17, col. 3)	$ 35,577
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
YAM Management	Bookkeeping	$ 57,035
YAM Consulting	Data Processing	11,345
Frost, Ruttenberg & Rothblatt	Accounting	17,400
YAM Management	Accounting	36,000
See Attached	Legal Fees	15,380
Pro Payroll Solutions, LLC	Payroll	9,664
Wescom Solutions	Data Processing	3,826
National Datacare Corporation	Financial Software	3,811
Personnel Planners	Unemployment Consultin	786
Risk Management services	Risk Management services	2,000
E-Health Data	Data Processing	1,855
See Supplemental Schedule		16,636
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 175,738

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 138,966
Unemployment Compensation Insurance	34,436
FICA Taxes	114,050
Employee Health Insurance	53,977
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension Fund	4,867
401K Expense	1,253
Employee Meals	1,138
Employee Benefits- Other	1,394
TOTAL (agree to Schedule V, line 22, col.8)	$ 350,081

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check	2,210
(Indicate # of checks performed 103)	
Patient Background Checks	
Dues & Subscriptions	5,958
Licenses and Permits	2,671
Allocated from YAM Consulting	865
Allocated from YAM Management	262
See Supplemental Schedule	6
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,952

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,440
Allocated from YAM Consulting	227
Allocated from YAM Management	108
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,775

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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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: 01/01/13 Ending: 12/31/13

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. **IL Council on LTC $5,426**

(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. $ **9,768** 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? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **97,929**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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