FOR BHF USE

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0035477

Facility Name: Exceptional Care & Training Center

Address: 2601 Woodlawn Road (Number) Sterling (City) 61081 (Zip Code)

County: Whiteside

Telephone Number: (815) 626-8520 **Fax #** (815) 626-8075

HFS ID Number:

Date of Initial License for Current Owners: 08/15/89

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501(c)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Kylie Waters Whipple **Telephone Number:** (859) 255-0075
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 7/1/09 to 6/30/10 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) Kylie Waters Whipple
(Title) Controller - Medical Rehabilitation Centers, Inc.

Paid Preparer

(Signed) (Date)
(Print Name and Title) Rick Mittman, Senior Managing Consultant
(Firm Name & Address) BKD, LLP, 201 North Illinois Street, Suite 700
(Telephone) (317) 383-4000 Fax # (317) 383-4200

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**

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/09 Ending: 6/30/10

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 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		Skilled (SNF)			1
2	84	Skilled Pediatric (SNF/PED)	84	30,660	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	84	TOTALS	84	30,660	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					8
9	SNF/PED	30,162	0	0	30,162	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,162			30,162	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.38%

D. How many bed-hold days during this year were paid by the Department?
169 (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 [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 08/15/89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/15/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/10 Fiscal Year: 6/30/10

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

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/09 Ending: 6/30/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	197,442	11,098	11,025	219,565	10,191	229,756		229,756			1
2	Food Purchase		176,316		176,316		176,316		176,316			2
3	Housekeeping	167,859	15,705	424	183,988	(28)	183,960		183,960			3
4	Laundry	142,739	7,501		150,240		150,240		150,240			4
5	Heat and Other Utilities			105,537	105,537	928	106,465		106,465			5
6	Maintenance	37,854	19,797	82,266	139,917	2,462	142,379		142,379			6
7	Other (specify):*											7
8	**TOTAL General Services**	545,894	230,417	199,252	975,563	13,553	989,116		989,116			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	1,788,556	101,308	12,855	1,902,719	(9,940)	1,892,779		1,892,779			10
10a	Therapy	11,336	712	15,278	27,326		27,326		27,326			10a
11	Activities	251,817	2,917	133	254,867	(57)	254,810		254,810			11
12	Social Services											12
13	CNA Training					26,237	26,237		26,237			13
14	Program Transportation		81	395	476		476		476			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,051,709	105,018	49,661	2,206,388	16,240	2,222,628		2,222,628			16
	C. General Administration											
17	Administrative	97,119		186,062	283,181	(165,431)	117,750	(20,801)	96,949			17
18	Directors Fees					16,770	16,770		16,770			18
19	Professional Services			495,727	495,727	62,437	558,164		558,164			19
20	Dues, Fees, Subscriptions & Promotions			12,298	12,298	300	12,598	(898)	11,700			20
21	Clerical & General Office Expenses	115,036	21,352	49,419	185,807	36,987	222,794	(679)	222,115			21
22	Employee Benefits & Payroll Taxes			555,687	555,687	9,501	565,188		565,188			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,925	12,925	128	13,053		13,053			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			37,970	37,970		37,970		37,970			26
27	Other (specify):* **Bad Debt**			(244)	(244)		(244)	244				27
28	**TOTAL General Administration**	212,155	21,352	1,349,844	1,583,351	(39,308)	1,544,043	(22,134)	1,521,909			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,809,758	356,787	1,598,757	4,765,302	(9,515)	4,755,787	(22,134)	4,733,653			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
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 & Training Center #0035477 **Report Period Beginning:** 7/1/09 **Ending:** 6/30/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			152,248	152,248	143	152,391		152,391			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			395,615	395,615	10,043	405,658	(70,954)	334,704			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds					1,534	1,534		1,534			34
35	Rent-Equipment & Vehicles			4,939	4,939	(159)	4,780		4,780			35
36	Other (specify):* **Amortization**			31,970	31,970		31,970	(22,833)	9,137			36
37	**TOTAL Ownership**			584,772	584,772	11,561	596,333	(93,787)	502,546			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			287,768	287,768		287,768		287,768			42
43	Other (specify):* **Day Training**	646,939	6,120	94,924	747,983	(2,046)	745,937		745,937			43
44	**TOTAL Special Cost Centers**	646,939	6,120	382,692	1,035,751	(2,046)	1,033,705		1,033,705			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,456,697	362,907	2,566,221	6,385,825		6,385,825	(115,921)	6,269,904			45

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

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/09 Ending: 6/30/10

VI. ADJUSTMENT DETAIL

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

	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
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	1,959	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(100)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	244	27		24
25	Fund Raising, Advertising and Promotional	(798)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(96,425)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (95,120)		$	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)	(20,801)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (20,801)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (115,921)		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.		X	$		38
39		X		SNF/PED		39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44			X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Exceptional Care & Training Center

ID# 0035477

Report Period Beginning: 7/1/09

Ending: 6/30/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Amortization - Goodwill (line 36)	$ (20,759)	36	1
2	Non-Allowable Bond Acquisition Costs (line 36)	(2,074)	36	2
3	Non-Allowable Interest Expense (line 32)	(72,913)	32	3
4	Miscellaneous Income (line 21)	(679)	21	4
5	Miscellaneous Income (line 6)			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				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**	(96,425)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Exceptional Care & Training Center # 0035477 **Report Period Beginning:** 7/1/09 **Ending:** 6/30/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(20,801)	0	0	0	0	0	0	0	0	0	(20,801)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(898)	0	0	0	0	0	0	0	0	0	0	(898)	20
21	Clerical & General Office Expenses	(679)	0	0	0	0	0	0	0	0	0	0	(679)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	244	0	0	0	0	0	0	0	0	0	0	244	27
28	**TOTAL General Administration**	(1,333)	(20,801)	0	0	0	0	0	0	0	0	0	(22,134)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,333)	(20,801)	0	0	0	0	0	0	0	0	0	(22,134)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Exceptional Care & Training Center # 0035477 **Report Period Beginning:** 7/1/09 **Ending:** 6/30/10

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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(70,954)	0	0	0	0	0	0	0	0	0	0	(70,954)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(22,833)	0	0	0	0	0	0	0	0	0	0	(22,833)	36
37	**TOTAL Ownership**	(93,787)	0	0	0	0	0	0	0	0	0	0	(93,787)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(95,120)	(20,801)	0	0	0	0	0	0	0	0	0	(115,921)	45

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/09 Ending: 6/30/10

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Swann Special Care Center	Champaign			
		Vernon Manor Children's Home	Wabash, Indiana			
		Walter Lawson Children's Home	Loves Park			
		Richland-Bean Blossom HCC	Ellettsville, Indiana			
		Exceptional Living Centers of Brazil	Brazil, Indiana			
		Clay County Nursing Center	Brazil, Indiana			
		Randolph Nursing Home	Winchester, Indiana			

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	17	Corporate Expense	$ 186,062	Hoosier Care, Inc.	100.00%	$ 165,261	$ (20,801)	1
2	V								2
3	V				Note: See Schedule VIII of allocation of cost per column 7.				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 186,062			$ 165,261	$ * (20,801)	14

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

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/09 Ending: 6/30/10

VII. RELATED PARTIES (continued)

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

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

	1	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: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Bruce Hutson, M.D.	Director	Board Meetings	0.00	11,574			Director Fees	$ 2,049	18.8	1
2	Stephen Wood	Director	Board Meetings	0.00	56,072			Director Fees	9,925	18.8	2
3	John Gillmor	Director	Board Meetings	0.00	15,957			Director Fees	2,825	18.8	3
4	John Foos	Director	Board Meetings	0.00	11,135			Director Fees	1,971	18.8	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 16,770		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

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/09 Ending: 6/30/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Hoosier Care, Inc.
Street Address: 535 West Second Street, Suite 105
City / State / Zip Code: Lexington, Kentucky 40508
Phone Number: (859) 255-0075
Fax Number: (859) 281-5150

	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	Revenue	45,772,634	8	$ 67,937	$ 0	6,883,897	$ 10,217	1
2	5	Heat & Other Utilities	Revenue	45,772,634	8	6,168	0	6,883,897	928	2
3	6	Maintenance	Revenue	45,772,634	8	5,340	0	6,883,897	803	3
4	10	Nursing / Medical Records	Revenue	45,772,634	8	103,189	0	6,883,897	15,520	4
5	18	Director's Fees	Revenue	45,772,634	8	111,508	0	6,883,897	16,770	5
6	19	Professional Fees	Revenue	45,772,634	8	415,140	0	6,883,897	62,437	6
7	20	Fees, Subscription & Promotion	Revenue	45,772,634	8	1,994	0	6,883,897	300	7
8	21	Clerical & General Office Exp.	Revenue	45,772,634	8	245,593	0	6,883,897	36,937	8
9	22	Emp. Benefits & Payroll Tax	Revenue	45,772,634	8	63,169	0	6,883,897	9,501	9
10	24	Travel & Seminar	Revenue	45,772,634	8	850	0	6,883,897	128	10
11	30	Depreciation	Revenue	45,772,634	8	950	0	6,883,897	143	11
12	32	Interest Expense	Revenue	45,772,634	8	66,775	0	6,883,897	10,043	12
13	34	Rent - Facility	Revenue	45,772,634	8	10,200	0	6,883,897	1,534	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					$ 1,098,813	$		$ 165,261	25

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/09 Ending: 6/30/10

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	City of Sterling Bonds - 1999A		X	Purchase of Facility	Varies	7/8/99	$ 4,775,000	$ 4,250,000	6/1/2034	7.1250	$ 305,989	1
2	City of Sterling Bonds - 1999B		X	Purchase of Facility	Varies	7/8/99	220,000	150,000	6/2/2019	10.5000	16,713	2
3												3
4												4
5												5
	Working Capital											
6	Corporate Allocation										10,043	6
7												7
8												8
9	TOTAL Facility Related						$ 4,995,000	$ 4,400,000			$ 332,745	9
	B. Non-Facility Related*											
10	Debt Allocation		X	Purchase of Facility	Varies	7/8/99		994,940	Varies	Varies	72,913	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$ 994,940			$ 72,913	14
15	TOTALS (line 9+line14)						$ 4,995,000	$ 5,394,940			$ 405,658	15

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

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

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

Facility Name & ID Number Exceptional Care & Training Center **#** 0035477 **Report Period Beginning:** 7/1/09 **Ending:** 6/30/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	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.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	None	8
	2006		9
	2007		10
	2008		11
	2009		12

Note: The facility became exempt from property taxes starting 1/1/96

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

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Exceptional Care & Training Center COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0035477

CONTACT PERSON REGARDING THIS REPORT Kylie Waters Whipple

TELEPHONE (859) 255-0075 FAX #: (859) 281-5150

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	TAX EXEMPT		$	$
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 X 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/09 Ending: 6/30/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,176 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [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	SNF/PED	63,598	1989	$ 414,085	1
2					2
3	TOTALS	63,598		$ 414,085	3

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/09 Ending: 6/30/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	64		1989		$ 2,334,000	$ 58,000	10-35	$ 58,000	$	$ 1,517,166	4
5	15			1991	358,311	11,944	30	11,944		227,489	5
6	5			2004							6
7											7
8											8
	Improvement Type**										
9	Boiler Repair			1990	964		10			964	9
10	Water Unit			1991	8,780		10			8,780	10
11	PA System			1991	696		10			696	11
12	Building Addition - Drywall			1991	403		10			403	12
13	Closet Curtain Track			1991	650		10			650	13
14	Door			1991	1,614		10			1,614	14
15	Boiler Repair			1992	6,180		10			6,180	15
16	Storm Windows			1992	907		10			907	16
17	Boiler Tubes			1992	7,147		10			7,147	17
18	Roof			1992	11,118		10			11,118	18
19	Kitchen Tile			1992	3,660		10			3,660	19
20	Heating & Cooling Unit			1992	7,757		10			7,757	20
21	Shed			1992	1,678		10			1,678	21
22	Gate & Fence Scars			1992	4,038		10			4,038	22
23	Landscaping			1992	2,398		10			2,398	23
24	Drain Replacement			1992	1,576		10			1,576	24
25	Black Top			1992	575		10			575	25
26	Light Fixtures			1992	3,743		10			3,743	26
27	Building Renovation			1993	139	5	30	5		79	27
28	Painting - Laundry			1993	351		10			351	28
29	Building Renovation			1993	7,106		10			7,106	29
30	Painting - Laundry			1993	262		10			262	30
31	Parking Lot			1993	1,800		10			1,800	31
32	Tile Installation			1993	1,020		10			1,020	32
33	Electrical Work			1993	3,255		10			3,255	33
34	Pipe Installation - Laundry			1993	156		10			156	34
35	Water Heater Renovation			1993	849		10			849	35
36	Final Payment - Laundry			1993	1,030		10			1,030	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

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/09 Ending: 6/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Replace Relay in Panel	1993	$ 1,150	$	10	$	$	$ 1,150	37
38	Install New Sewer Lines	1993	4,105		10			4,105	38
39	New Water Main	1993	12,204		10			12,204	39
40	Replace Parts on Sump Pumps	1994	4,034		10			4,034	40
41	Installed Back Flow Preventor	1994	1,053		10			1,053	41
42	Large Toilet Support, Back Stop	1994	923		10			923	42
43	Deck	1994	814		10			814	43
44	New Roof	1994	29,435		10			29,435	44
45	Tile Floors in Tub Room	1994	4,405		10			4,405	45
46	Thermocouple on Boiler	1995	2,550		10			2,550	46
47	New Pump on Boiler System	1995	1,706		10			1,706	47
48	Air Conditioner Compressor	1995	1,668		10			1,668	48
49	Replace Fire Alarm	1995	3,743		10			3,743	49
50	Landscaping	1995	15,000		10			15,000	50
51	Counter Top	1995	527		10			527	51
52	New Door Frame Installed	1995	959		10			959	52
53	Rebuild Corner of Building	1996	2,000		10			2,000	53
54	Install Two Bell - Strobes	1996	888		10			888	54
55	Replace Relay & Timer on Generator	1996	1,325		10			1,325	55
56	Rebuild Commercial Water Softener	1996	1,880		10			1,880	56
57	Replace 3/4 H.P. Motor, Thermocoupler	1996	920		10			920	57
58	Replace Boiler Pumps and Bearing Assembly	1997	640		10			640	58
59	Install 3/4 H.P. Motor-Boiler	1997	725		10			725	59
60	Replace Circulating Pump, Bearings	1997	743		10			743	60
61	Twenty New Water Faucets	1997	2,296		10			2,296	61
62	Vinyl Floor Tile-Resident Room	1997	690		10			690	62
63	Reseal Parking Area	1997	2,845		10			2,845	63
64	Air Conditioning Condenser Unit	1997	1,650		10			1,650	64
65	Install Conduit	1997	913		10			913	65
66	Outlets & Wiring	1997	522		10			522	66
67	Kitchen Fire Suppression System	1998	767		10			767	67
68	Smoke Detectors	1998	621		10			621	68
69	Install Pipe & Wire	1998	995		10			995	69
70	TOTAL (lines 4 thru 69)		$ 2,876,859	$ 69,949		$ 69,949	$	$ 1,929,143	70

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

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/09 Ending: 6/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,876,859	$ 69,949		$ 69,949	$	$ 1,929,143	1
2	Smoke Detectors	1998	1,645		10			1,645	2
3	Tank Replacement - PIPECO	1998	9,890	495	20	495		5,853	3
4	Generator and Transfer Switch Changeover	1998	2,746		10			2,746	4
5	Replace Tubes on Boiler, Galv. Pipes on Water Line	1998	1,690		10			1,690	5
6	Installed Boiler Control and Switch for Light	1998	709		10			709	6
7	Replace Faulty Smoke Detectors, Installed Batteries	1998	973		10			973	7
8	Installed Tile on Walls & in Staircase (New Addition)	1998	4,495		10			4,495	8
9	Two Hot Water Tanks Installed	1999	7,119		10			7,119	9
10	Installation Heavier Electric Service for Dishwasher	1999	1,651		10			1,651	10
11	Install New Cooling System Laundry / Kitchen	2000	4,650	233	20	233		2,441	11
12	Plaster & Drywall Existing Walls in Residents Rooms	2000	800	47	10	47		800	12
13	Install New Tile in Dinning Area & Two Classrooms	2000	4,770	318	15	318		3,260	13
14	Installed New Thermocuople on West Boiler	2000	353	27	10	27		353	14
15	Replace Thermocouple on West Boiler	2000	140	11	10	11		140	15
16	Replace Thermocouple on Inducer Fan	2000	215	17	10	17		215	16
17	Rebuilt Two Hopper Foot Valves / Installed Protectorelay	2000	1,430	108	10	108		1,430	17
18	Replace Coupler, Motor Mounts, Bearing assy, Impeller	2000	298	22	10	22		298	18
19	Labor to Install 120V Power to New Door Openers	2000	583	49	10	49		583	19
20	Replaced Bearing Assy on Hot Water Return Line	2000	518	43	10	43		518	20
21	Indicator Lamps & Voltage	2000	1,525	153	10	153		1,487	21
22	Replace Heat Exchanger	2001	962	96	10	96		914	22
23	Replace Heat Exchanger	2001	962	96	10	96		906	23
24	Replace Draft Inducer	2001	1,414	141	10	141		1,320	24
25	Replace Pipe	2001	530	53	10	53		495	25
26	Replace Clinical Sink	2001	2,304	154	15	154		1,421	26
27	Furnish & Install Awning	2001	2,771	185	15	185		1,709	27
28	Labor & Mat-Breaker Panel	2001	3,930	262	15	262		2,423	28
29	Install Thermo Coupler	2001	944	94	10	94		865	29
30	Install Electric For Dishwasher	2001	820	55	15	55		501	30
31	Reroof Facility and Garage	2001	13,960	558	25	558		5,119	31
32	Lusterboard Sign	2001	515		5			515	32
33	Excavation of New Parking	2001	12,415	621	20	621		5,690	33
34	TOTAL (lines 1 thru 33)		$ 2,964,586	$ 73,787		$ 73,787	$	$ 1,989,426	34

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

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/09 Ending: 6/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,964,586	$ 73,787		$ 73,787	$	$ 1,989,426	1
2	Renovation Installment	2001	63,363		5			63,363	2
3	Concrete for Canapy & Add.	2001	2,592		5			2,592	3
4	Reconfigure Changing area	2001	3,393		5			3,393	4
5	Refund Electrical Panel	2001	(975)		5			(975)	5
6	Install Water Heater	2001	3,341	223	15	223		2,005	6
7	Conduit & Wiring for Door Holders	2001	1,982	132	15	132		1,189	7
8	Air Conditioning in Lobby-Motor Replacement	2001	349	35	10	35		311	8
9	East Tub Room Fan-Motor Replacement	2001	213	21	10	21		190	9
10	Dryer Vent Replacement	2001	319	32	10	32		284	10
11	Reconfigure Water Heater Room	2001	1,860	124	15	124		1,095	11
12	Walkway	2001	4,120	275	15	275		2,448	12
13	Hand Railing on Stairs to Upper Parking Lot	2002	2,130	142	15	142		1,171	13
14	Privacy Fence	2002	2,550	255	10	255		2,061	14
15	Install Temp Control Cartridge-Boiler	2002	537	36	15	36		304	15
16	Internet Set Up Wiring, Cable	2002	3,061	204	10	204		1,717	16
17	Motor Boiler	2002	763	76	10	76		636	17
18	Replace Hallow Metal Door	2002	1,665	111	15	111		897	18
19	Shutters	2002	820	82	10	82		663	19
20	Storm Window Project	2002	8,937	447	20	447		3,612	20
21	Replace Breaker, Ballasts	2002	555		5			555	21
22	Tennant Allowance to Offset Fix-up Costs	2002	(5,000)		5			(5,000)	22
23	New Motor on Boiler	2002	962	96	10	96		770	23
24	Installed Hospital Grade Outlet	2002	2,256	226	10	226		1,786	24
25	Wiring for New Time Clock	2003	634	63	10	63		460	25
26	Motor & Coupler / Circular	2003	835	83	10	83		605	26
27	Side Screens on DT Awning	2003	738		5			738	27
28	Anne's Landscaping	2004	590	59	10	59		364	28
29	Parking Lot Renovation	2004	3,049	305	10	305		1,779	29
30	Parking Lot Renovation	2004	450	45	10	45		225	30
31	Fire & Electric System (Part of 298)	2004	435	62	7	62		367	31
32	New Electrical System (Multi Purpose)	2004	6,637	948	7	948		5,531	32
33	Conduit and Wire Hookup	2004	965	97	10	97		539	33
34	TOTAL (lines 1 thru 33)		$ 3,078,712	$ 77,966		$ 77,966	$	$ 2,085,103	34

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

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/09 Ending: 6/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,078,712	$ 77,966		$ 77,966	$	$ 2,085,103	1
2	34 Heat / Smoke Detectors	2004	2,800	400	7	400		2,233	2
3	Commerical Disposal	2005	551	79	7	79		433	3
4	18 Kickplates	2005	2,215	222	10	222		1,200	4
5	Hollow Metal Door	2005	945	63	15	63		320	5
6	Day Training Addition	2005	346,465	11,549	30	11,549		67,368	6
7	3 Window A/C Units	2005	1,755	251	5	251		1,254	7
8	Compressor in Lobby - Replacement	2005	11,445	763	15	763		3,751	8
9	2 A/C Units	2005	1,170	167	7	167		808	9
10	Booster Pump / Shower Head - Replacement	2005	943	94	10	94		432	10
11	Hot Water Mixing Valve - Replacement	2005	1,168	117	10	117		545	11
12	Install Pull Station / Light / Speaker	2005	1,434	143	10	143		681	12
13	New Roof (down payment)	2006	15,987	1,599	10	1,599		6,928	13
14	Sprinkler System- Phase I	2006	33,165	2,211	15	2,211		8,844	14
15	Water Heater	2006	4,717	472	10	472		1,887	15
16	3 A/C Units	2006	1,755	251	7	251		1,003	16
17	Fire Door for Tub Room	2006	640	64	10	64		256	17
18	Sprinkler System- Phase II	2006	7,920	528	15	528		2,112	18
19	Sprinkler System- Phase III	2006	13,365	891	15	891		3,341	19
20	Sprinkler System- Phase IV	2006	1,978	132	15	132		473	20
21	Light Fixtures and Wiring	2007	6,434	429	15	429		1,465	21
22	Ductwork & Roof Exhaust	2007	3,498	233	15	233		777	22
23	Brake Assembly on Dumbwaiter	2007	4,389	293	15	293		853	23
24	Air Conditioning Window Units	2007	1,170	167	7	167		501	24
25	Raise Sidewalks	2007	950	95	15	95		285	25
26	Tile Walls	2008	9,300	620	15	620		1,498	26
27	Privacy Walls	2008	3,297	220	15	220		458	27
28	Pistons & Gears for Water Softner System	2008	947	95	10	95		213	28
29	Door Assembly for Boiler	2007	1,072	107	10	107		321	29
30	Parking Lot Replaced/Resurfaced	2008	3,670	367	10	367		612	30
31	A/C Wall Units (4)	2008	1,841	184	10	184		353	31
32	5 Ton A/C Compressor	2008	2,000	200	10	200		383	32
33	Cabinets for south day room	2008	908	61	15	61		111	33
34	TOTAL (lines 1 thru 33)		$ 3,568,606	$ 101,033		$ 101,033	$	$ 2,196,804	34

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

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/09 Ending: 6/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,568,606	$ 101,033		$ 101,033	$	$ 2,196,804	1
2	Smoke detectors (5)	2008	1,631	163	10	163		299	2
3	Wiring & outlets for kitchen & dayrooms	2008	3,434	229	15	229		401	3
4	Circulating pump for kitchen	2008	678	68	10	68		113	4
5	Exit & boiler room doors replaced	2008	2,712	181	15	181		271	5
6	Aquastat replaced on boiler	2008	533	53	10	53		80	6
7	Boiler ventilation motor delay switch	2008	1,716	172	10	172		272	7
8	Bearings for hot water circulating pump	2009	736	49	15	49		65	8
9	(Transfer) Roof west bldg & gazebo & continuous gutters	2009		(454)	20	(454)			9
10	Avaya phone system for day training	2009	7,010	701	10	701		759	10
11	Cabinets & counter for education bldg kitchen	2009	1,162	77	15	77		83	11
12	Hot water circulation pump	2009	517	52	10	52		60	12
13	Remodel employee/public restrooms (2)	2009	1,722	172	10	172		172	13
14	Convert 2 classrooms to 1 & remodel restroom	2009	2,846	190	15	190		190	14
15	Sewage pump	2009	4,133	413	10	413		585	15
16	Electrical outlets for food service	2009	1,419	95	15	95		95	16
17	5 ton rooftop hvac unit	2009	6,485	432	15	432		432	17
18	26 X 12 storage shed	2009	8,280	552	15	552		552	18
19	Water heater (2)	2009	11,250	1,031	10	1,031		1,031	19
20	Cabinets for education building	2009	562	34	15	34		34	20
21	Fire damper for laundry air intake	2009	1,452	81	15	81		81	21
22	Induct air purifiers (5)	2009	1,690	99	10	99		99	22
23	Concrete sidewalk for emergency exit	2009	7,119	435	15	435		435	23
24	Trex security fence	2009	9,142	457	15	457		457	24
25	Replacement parts on rooftop RTUs	2010	1,737	72	10	72		72	25
26	Shaft for boiler exhaust	2010	512	26	10	26		26	26
27	Bearing assembly for hot water pump in kitchen	2010	522	13	10	13		13	27
28	Roof for courtyard pavillion	2010	6,657	37	15	37		37	28
29	120 volt electrical outlet for air purifiers	2010	781	4	15	4		4	29
30	Grease trap replace and electric & tile repair	2010	7,217	40	15	40		40	30
31	Steel roll-up door for dumpster enclosure	2010	1,399	58	10	58		58	31
32	Rounding		(4)	(5)		(5)		2	32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,663,655	$ 106,559		$ 106,559	$	$ 2,203,624	34

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

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/09 Ending: 6/30/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 145,373	$ 26,614	$ 26,614	$		$ 81,345	71
72	Current Year Purchases	117,719	7,662	7,662			7,662	72
73	Fully Depreciated Assets	516,324	1,194	1,194			516,325	73
74	Corporate Allocation		143	143				74
75	TOTALS	$ 779,416	$ 35,613	$ 35,613	$		$ 605,332	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1995 Ford Van	1998	$ 2,071	$	$	$		$ 2,071	76
77	Patient Transportation	2002 Van	2002	19,705					19,705	77
78	Patient Transportation	2002 Van	2002	11,803	150	150			11,716	78
79	Patient Transportation	See Attached	2008-2010	118,519	10,069	10,069			17,711	79
80	TOTALS			$ 152,098	$ 10,219	$ 10,219	$		$ 51,203	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)	$ 5,009,254	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 152,391	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 152,391	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,860,159	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	Construction in progress	$ 11,187	92
93			93
94			94
95		$ 11,187	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

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

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/09 Ending: 6/30/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Corporate Allocation				1,534			5
6								6
7	TOTAL				$ 1,534 **			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.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 4,780 Description: See Attached
    (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			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	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.

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/09 Ending: 6/30/10

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? [X] YES [ ] NO

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

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER CNA 80

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			171		171
3	Classroom Wages	(a)		3,704		3,704
4	Clinical Wages	(b)		21,404		21,404
5	In-House Trainer Wages	(c)		958		958
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$	$ 26,237	$	$ 26,237
10	SUM OF line 9, col. 1 and 2	(e)	$ 26,237			

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	26
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	26

(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.

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/09 Ending: 6/30/10

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	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.

STATE OF ILLINOIS

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/09 Ending: 6/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/10 (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	$ 51,526	$	1
2	Cash-Patient Deposits	55,234		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 698)	505,854		3
4	Supply Inventory (priced at Cost)			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,012		6
7	Other Prepaid Expenses	9,738		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Corporate	13,054,219		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 13,711,583	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	414,085		13
14	Buildings, at Historical Cost	3,598,989		14
15	Leasehold Improvements, at Historical Cost	64,666		15
16	Equipment, at Historical Cost	931,514		16
17	Accumulated Depreciation (book methods)	(2,860,159)		17
18	Deferred Charges	269,059		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	491,115		22
23	Other(specify): Goodwill	396,154		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,305,423	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 17,017,006	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 196,366	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	55,234		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	231,277		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,063		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	32,551		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 527,491	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,394,940		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,394,940	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,922,431	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,094,575	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 17,017,006	$	48

*(See instructions.)

Facility Name & ID Number Exceptional Care & Training Center **#** 0035477 **Report Period Beginning:** 7/1/09 **Ending:** 6/30/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 10,466,163	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,466,163	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	628,412	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 628,412	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)**	$ 11,094,575	24 *

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

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/09 Ending: 6/30/10

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,283,805	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,283,805	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	14,175	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	35,497	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 49,672	23
	D. Non-Operating Revenue		
24	Contributions	110,740	24
25	Interest and Other Investment Income***	(1,959)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 108,781	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DMH Day Training	1,568,941	28
28a	Miscellaneous Income	3,031	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,571,972	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,014,230	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	975,563	31
32	Health Care	2,206,388	32
33	General Administration	1,583,351	33
	B. Capital Expense		
34	Ownership	584,772	34
	C. Ancillary Expense		
35	Special Cost Centers	747,983	35
36	Provider Participation Fee	287,768	36
	D. Other Expenses (specify):		
37	Rounding	(7)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,385,818	40
41	**Income before Income Taxes (line 30 minus line 40)****	628,412	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 628,412	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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.**

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/09 Ending: 6/30/10

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	1,966	2,186	$ 64,238	$ 29.39	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,021	6,440	171,268	26.59	3
4	Licensed Practical Nurses	22,181	24,158	500,044	20.70	4
5	CNAs & Orderlies	83,963	91,560	1,053,006	11.50	5
6	CNA Trainees					6
7	Licensed Therapist	321	342	11,336	33.15	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,968	2,002	38,665	19.31	9
10	Activity Assistants	19,731	21,297	213,152	10.01	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,060	2,188	38,586	17.64	13
14	Head Cook	6,312	6,942	82,716	11.92	14
15	Cook Helpers/Assistants	7,824	8,336	76,140	9.13	15
16	Dishwashers					16
17	Maintenance Workers	2,045	2,200	37,854	17.21	17
18	Housekeepers	12,722	14,030	167,859	11.96	18
19	Laundry	11,322	12,392	142,739	11.52	19
20	Administrator	2,064	2,284	97,119	42.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,601	5,064	115,036	22.72	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) Day Training	48,075	52,303	646,939	12.37	33
34	TOTAL (lines 1 - 33)	233,176	253,724	$ 3,456,697 *	$ 13.62	34

* 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	N/A	$ 9,683	1.3	35
36	Medical Director	N/A	21,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	N/A	2,603	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	N/A	14,743	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	N/A	6,000	10.3	46
47	Other Plant Operation	N/A	40,207	6.3	47
48	Other (See Attached)	57	1,583		48
49	TOTAL (lines 35 - 48)	57	$ 95,819		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

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/09 Ending: 6/30/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Melissa Francque	Administrator	0	$ 97,119
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 97,119

B. Administrative - Other

Description	Amount
Corporate Expense	$ 186,062
TOTAL (agree to Schedule V, line 17, col. 3)	$ 186,062
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Medical Rehabilitation Centers, Inc	Management Fees	$ 433,200
BKD, LLP	Accounting Fees	4,750
Constance Rosen	Accounting Fees	256
Medical Rehabilitation Centers, Inc	Legal Fees	8,776
Duane Morris, LLP	Legal Fees	26,951
Taft, Stettinius, & Hollister, LLP	Legal Fees	159
Smith Admunsen LLC	Legal Fees	18,433
Stoll, Keenon, Ogden, PLLC	Legal Fees	2,066
Dewitt, Ross & Stevens	Legal Fees	273
Mallor, Clendening, Grodner, & Boh	Legal Fees	99
Bradley Arant Boult Cummings	Legal Fees	55
Marvin G. Ripley	Legal Fees	709
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 495,727

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 92,144
Unemployment Compensation Insurance	(5,233)
FICA Taxes	288,180
Employee Health Insurance	171,634
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement Plan	4,464
Employee Benefits- Other	4,498
Corporate Allocation	9,501
TOTAL (agree to Schedule V, line 22, col.8)	$ 565,188

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

Description	Line #	Amount
None		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 43)	1,821
Illinois Health Care Assoc.	4,637
MES of Illinois	175
NAEIR	147
Corporate Allocation	300
Chamber of Commerce	100
Other Fees	5,418
Less: Public Relations Expense	(898)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,700

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
Non-Allowable	0
In-State Travel	4,579
Non-Allowable	0
Seminar Expense	8,346
Corporate Allocation	128
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,053

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/09 Ending: 6/30/10

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	None		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Exceptional Care & Training Center **#** 0035477 **Report Period Beginning:** 7/1/09 **Ending:** 6/30/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **See Schedule XIX, Section F**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(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? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **24,000** Line **10.2**

(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. $ **287,768**
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? **Yes** If YES, attach an explanation of the allocation.

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

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

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

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **4,346**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
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? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ **50,153**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Reznick Group**

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

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