FOR BHF USE

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

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

I. IDPH License ID Number: 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: 08/18/1989

Type of Ownership:

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

IRS Exemption Code 501(c)(3)

In the event there are further questions about this report, please contact:
Name: Charles Smith **Telephone Number:** (859) 317-4040
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 07/01/2010 to 06/30/2011 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) Tom Watts

(Title) Chief Manager

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Charles Smith, Reimbursement Manager

(Firm Name & Address) Exceptional Living Centers, 535 W Second Street, Suite 105

(Telephone) (859) 317-4040 Fax # ( )

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: 07/01/2010 Ending: 06/30/2011

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	30,498			30,498	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,498			30,498	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.47%

D. How many bed-hold days during this year were paid by the Department?
153 (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 08/15/1989

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/15/1989 NO [ ]

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

Medicare Intermediary Non Applicable

IV. ACCOUNTING BASIS

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

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

Tax Year: 06/30/2011 Fiscal Year: 06/30/2011

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

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	180,002	11,561	12,394	203,957	16,442	220,399		220,399			1
2	Food Purchase		130,005		130,005		130,005		130,005			2
3	Housekeeping	170,867	13,144		184,011		184,011		184,011			3
4	Laundry	147,994	5,968	1,428	155,390		155,390		155,390			4
5	Heat and Other Utilities			97,852	97,852	717	98,569		98,569			5
6	Maintenance	45,605	18,081	59,239	122,925	899	123,824		123,824			6
7	Other (specify):*											7
8	**TOTAL General Services**	544,468	178,759	170,913	894,140	18,058	912,198		912,198			8
	B. Health Care and Programs											
9	Medical Director			27,300	27,300		27,300		27,300			9
10	Nursing and Medical Records	1,740,237	88,601	38,237	1,867,075	(5,237)	1,861,838		1,861,838			10
10a	Therapy	6,358	352	6,074	12,784		12,784		12,784			10a
11	Activities	266,415	2,920	963	270,298		270,298		270,298			11
12	Social Services											12
13	CNA Training					25,108	25,108		25,108			13
14	Program Transportation		84	23,872	23,956		23,956		23,956			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,013,010	91,957	96,446	2,201,413	19,871	2,221,284		2,221,284			16
	C. General Administration											
17	Administrative	103,142	24,666	279,293	407,101	(181,834)	225,267	(92,087)	133,180			17
18	Directors Fees					7,053	7,053		7,053			18
19	Professional Services			541,122	541,122	17,510	558,632		558,632			19
20	Dues, Fees, Subscriptions & Promotions			13,353	13,353	45,328	58,681	(1,522)	57,159			20
21	Clerical & General Office Expenses	97,532		47,707	145,239	9,692	154,931	(32,812)	122,119			21
22	Employee Benefits & Payroll Taxes			560,819	560,819	49,052	609,871		609,871			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,567	14,567	7	14,574	(1,253)	13,321			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			36,364	36,364		36,364		36,364			26
27	Other (specify):*			66	66		66		66			27
28	**TOTAL General Administration**	200,674	24,666	1,493,291	1,718,631	(53,192)	1,665,439	(127,674)	1,537,765			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,758,152	295,382	1,760,650	4,814,184	(15,263)	4,798,921	(127,674)	4,671,247			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: 07/01/2010 Ending: 06/30/2011

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			180,420	180,420	246	180,666		180,666			30
31	Amortization of Pre-Op. & Org.			11,211	11,211		11,211		11,211			31
32	Interest			388,136	388,136	13,568	401,704	(12,714)	388,990			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds					1,449	1,449		1,449			34
35	Rent-Equipment & Vehicles			5,453	5,453		5,453		5,453			35
36	Other (specify):*							(11,211)	(11,211)			36
37	**TOTAL Ownership**			585,220	585,220	15,263	600,483	(23,925)	576,558			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			290,384	290,384		290,384		290,384			42
43	Other (specify):*	707,916	6,283	95,664	809,863		809,863		809,863			43
44	**TOTAL Special Cost Centers**	707,916	6,283	386,048	1,100,247		1,100,247		1,100,247			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,466,068	301,665	2,731,918	6,499,651		6,499,651	(151,599)	6,348,052			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: 07/01/2010 Ending: 06/30/2011

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	(12,714)	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				17
18	Fines and Penalties				18
19	Entertainment	(929)	24		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				24
25	Fund Raising, Advertising and Promotional	(1,522)	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	(331)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (15,496)		$	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)	92,087		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 92,087		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 76,591		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						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						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Exceptional Care & Training Center

ID# 0035477

Report Period Beginning: 07/01/2010

Ending: 06/30/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Amortization of Goodwill	$ (11,211)	36	1
2	Miscellaneous Income	(32,812)	21	2
3	Out-of-State Travel	(324)	24	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				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**	(44,347)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Exceptional Care & Training Center # 0035477 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

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	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	(92,087)	0	0	0	0	0	0	0	0	0	(92,087)	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	(1,522)	0	0	0	0	0	0	0	0	0	0	(1,522)	20
21	Clerical & General Office Expenses	(32,812)	0	0	0	0	0	0	0	0	0	0	(32,812)	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	(1,253)	0	0	0	0	0	0	0	0	0	0	(1,253)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(35,587)	(92,087)	0	0	0	0	0	0	0	0	0	(127,674)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(35,587)	(92,087)	0	0	0	0	0	0	0	0	0	(127,674)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Exceptional Care & Training Center # 0035477 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

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	(12,714)	0	0	0	0	0	0	0	0	0	0	(12,714)	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):*	(11,211)	0	0	0	0	0	0	0	0	0	0	(11,211)	36
37	**TOTAL Ownership**	(23,925)	0	0	0	0	0	0	0	0	0	0	(23,925)	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)**	(59,512)	(92,087)	0	0	0	0	0	0	0	0	0	(151,599)	45

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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
		Swann Specail Care Center	Champaign			
		Walter Lawson Childrens Home	Loves Park			
		Vernon Manor Childrens Home	Wabash, Indiana			
		Exceptional Living Centers of Brazil	Brazil, Indiana			
		Randolph Nursing Home	Winchester, Indiana			
		Richland-Bean Blossom HCC	Ellettsville, 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. ☐ 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	$ 275,025	Hoosier Care, Inc.	100.00%	$ 182,938	$ (92,087)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 275,025			$ 182,938	$ * (92,087)	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: 07/01/2010 Ending: 06/30/2011

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

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	Bruce Hutson, M.D.	Director	Board Meetings	0.00				Director Fee	$ 1,126	18 / 3	1
2	Stephen Wood	Director	Board Meetings	0.00				Director Fee	3,515	18 / 3	2
3	John Gillmor	Director	Board Meetings	0.00				Director Fee	1,286	18 / 3	3
4	John Foos	Director	Board Meetings	0.00				Director Fee	1,126	18 / 3	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 7,053		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: 07/01/2010 Ending: 6/30/2011

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	Dietary	Revenue	49,258,737	7	$ 114,973	$	7,044,281	$ 16,442	1
2	5	Heat & Other Utilities	Revenue	49,258,737	7	5,016		7,044,281	717	2
3	6	Maintenance	Revenue	49,588,737	7	6,331		7,044,281	899	3
4	10	Nursing/Medical Records	Revenue	49,588,737	7	139,883		7,044,281	19,871	4
5	18	Directors Fees	Revenue	49,588,737	7	49,648		7,044,281	7,053	5
6	19	Professional Services	Revenue	49,588,737	7	123,265		7,044,281	17,510	6
7	20	Dues, Subscriptons & Fees	Revenue	49,588,737	7	319,030		7,044,281	45,320	7
8	21	Clerical General Office Exp.	Revenue	49,588,737	7	68,230		7,044,281	9,692	8
9	22	Emp. Benefits & Payroll	Revenue	49,588,737	7	345,306		7,044,281	49,052	9
10	24	Travel & Seminar	Revenue	49,588,737	7	108		7,044,281	15	10
11	30	Depreciation	Revenue	49,588,737	7	1,735		7,044,281	246	11
12	32	Interest-Working Capital	Revenue	49,588,737	7	95,510		7,044,281	13,568	12
13	34	Rent- Facility	Revenue	49,588,737	7	10,200		7,044,281	1,449	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					$ 1,279,235	$		$ 181,834	25

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	$ 4,180,000	6/1/2034	7.1250	$ 301,566	1
2	City of Sterling Bonds - 1999B		X	Purchase of Facility	Varies	7/8/99	220,000	140,000	6/2/2019	10.5000	15,488	2
3												3
4												4
5												5
	Working Capital											
6	Corporate Allocation										13,658	6
7												7
8												8
9	TOTAL Facility Related						$ 4,995,000	$ 4,320,000			$ 330,712	9
	B. Non-Facility Related*											
10	Debt Allocation		X	Purchase of Facility	Varies	7/8/99	994,940		Varies	Varies	71,083	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 994,940	$			$ 71,083	14
15	TOTALS (line 9+line14)						$ 5,989,940	$ 4,320,000			$ 401,795	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: 07/01/2010 Ending: 06/30/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 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 2011 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:			
	2006	None	8
	2007	None	9
	2008	None	10
	2009	None	11
	2010	None	12

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

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Exceptional Care & Training Center COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0035477

CONTACT PERSON REGARDING THIS REPORT Charles Smith

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

	(A) 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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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).

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: 07/01/2010 Ending: 06/30/2011

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	64		1989		$ 2,334,000	$ 58,000	10-35	$ 58,000	$	$ 1,575,166	4
5	15			1991	358,311	11,944	30	11,944		239,432	5
6	5			2004							6
7											7
8											8
	Improvement Type**										
9	MAJOR BOILER REPAIR			1990	964		10			964	9
10	REPLACE WATER UNIT			1991	8,780		10			8,780	10
11	XFORMERS/PA SYSTEM - TECT			1991	696		10			696	11
12	BLDG ADDTN DRYWALL - INST			1991	403		10			403	12
13	CLOSET CURTAIN TRACK-GM C			1991	650		10			650	13
14	DOOR - C&E GLASS			1991	1,614		10			1,614	14
15	BOILER VALVE -SCHMIDT			1992	803		10			803	15
16	HEAT EXCHANGER/BOILER-SCH			1992	1,315		10			1,315	16
17	REPLACE HEAT EXCHANGER-SC			1992	4,062		10			4,062	17
18	STORM WINDOWS - C&E GLASS			1992	907		10			907	18
19	BOILER TUBES - SCHMIDT PL			1992	7,147		10			7,147	19
20	ROOF - HAUS BLDRS			1992	11,118		10			11,118	20
21	KITCHEN TILE SCHMIDT & AS			1992	3,660		10			3,660	21
22	HEATING & COOLING UNIT SC			1992	7,757		10			7,757	22
23	SHED			1992	1,678		10			1,678	23
24	GATE & FENCE SCARS			1992	4,038		10			4,038	24
25	LANDSCAPING MEGLI LAWN CA			1992	2,397		10			2,397	25
26	DRAIN REPLACEMENT/GBG DIS			1992	1,576		10			1,576	26
27	BLACKTOP WORK			1992	575		10			575	27
28	LIGHT FIXTURES			1992	3,743		10			3,743	28
29	BUILDING RENOVATION			1992	139	5	30	5		89	29
30	PAINT NEW LAUNDRY ROOM			1992	351		10			351	30
31	BUILDING RENOVATION/REMOD			1993	7,105		10			7,105	31
32	PAINT NEW LAUNDRY ROOM			1993	262		10			262	32
33	SEAL AND RESTRIPE PARKING			1993	1,800		10			1,800	33
34	INSTALL TILE			1993	730		10			730	34
35	INSTALL TILE			1993	290		10			290	35
36	ELECTRICAL WORK			1993	3,255		10			3,255	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: 07/01/2010 Ending: 06/30/2011

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	INSTALL PIPE/WIRE FOR LAU	1993	$ 156	$	10	$	$	$ 156	37
38	RENOVATE WATER HEATER	1993	849		10			849	38
39	FINAL PMT ON LAUNDRY PROJ	1993	1,030		10			1,030	39
40	REPLACE RELAY IN PANEL	1993	1,149		10			1,149	40
41	INSTALL NEW SEWER LINES	1993	4,105		10			4,105	41
42	NEW WATER MAIN	1993	12,204		10			12,204	42
43	REPLACE PARTS ON 2 SUMP P	1994	4,034		10			4,034	43
44	INSTALLED BACKFLOW PREVEN	1994	1,053		10			1,053	44
45	LG TOILET SUPPORT,BACK &	1994	923		10			923	45
46	DECK	1994	814		10			814	46
47	NEW ROOF	1995	29,435		10			29,435	47
48	TILE FOR FLOORS IN TUB RO	1995	4,405		10			4,405	48
49	THERMOCOUPLE ON BOILER	1995	2,550		10			2,550	49
50	NEW PUMP ON BOILER SYSTEM	1995	1,706		10			1,706	50
51	AIR CONDITIONER COMPRESSO	1995	1,668		10			1,668	51
52	REPLACE FIRE ALARM	1995	3,743		10			3,743	52
53	LANDSCAPING	1995	15,000		10			15,000	53
54	COUNTERTOP	1995	527		10			527	54
55	NEW DOOR & FRAME INSTALLE	1995	959		10			959	55
56	REBUILD CORNER OF BUILDIN	1996	2,000		10			2,000	56
57	INSTALL TWO BELL-STROBES	1996	888		10			888	57
58	REPLACE RELAY ON GENERATO	1996	1,325		10			1,325	58
59	REBUILD WATER SOFTENER	1995	1,880		10			1,880	59
60	REPL 3/4HP MOTOR,THERMOCO	1996	920		10			920	60
61	REPL BOILER PUMPS,BEARING	1997	640		10			640	61
62	INSTALL 3/4HP MOTOR-BOILE	1997	725		10			725	62
63	REPL CIRCULATING PUMP,BEA	1997	743		10			743	63
64	TWENTY NEW WATER FAUCETS	1997	2,296		10			2,296	64
65	VINYL FLOOR TILE-RESIDENT	1997	690		10			690	65
66	RESEAL PARKING AREA	1997	2,845		10			2,845	66
67	AIR CONDITIONING CONDENSE	1997	1,650		10			1,650	67
68	INSTALL CONDUIT;MORE AMPE	1997	913		10			913	68
69	REPLACE OUTLETS/WIRING RE	1997	522		10			522	69
70	TOTAL (lines 4 thru 69)		$ 2,874,475	$ 69,949		$ 69,949	$	$ 1,996,712	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: 07/01/2010 Ending: 06/30/2011

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		$ 2,874,475	$ 69,949		$ 69,949	$	$ 1,996,712	1
2	REPLACE KITCHEN FIRE SYST	1998	767		10			767	2
3	REPLACED SMOKE DETECTORS	1998	621		10			621	3
4	INSTALL ANSIL SYS PIPE/WI	1998	995		10			995	4
5	REPLACED SIX SMOKE DETECT	1998	1,645		10			1,645	5
6	TANK REPLACEMENT - PIPECO	1998	9,890	495	20	495		6,346	6
7	PART:GENERATOR,TRANSFER S	1998	2,746		10			2,746	7
8	TUBES-BOILER;PIPES-WATER	1998	1,690		10			1,690	8
9	BOILER CONTROL;SWITCH: LI	1998	709		10			709	9
10	REPLACE FAULTY SMOKE DETE	1998	973		10			973	10
11	INSTALL TILE:WALLS,STAIRC	1998	4,495		10			4,495	11
12	2 HOT WATER TANKS	1999	7,119		10			7,119	12
13	INSTALL HEAVY ELEC.SERVIC	1999	1,651		10			1,651	13
14	COOLING SYSTEM-LAUNDRY/KI	2000	4,650	233	20	233		2,674	14
15	PLASTER/DRYWALL RESIDENT	2000	800		10			800	15
16	NEW TILE IN DINING RM/CLA	2000	4,770	318	15	318		3,578	16
17	INSTALL THERMOCOUPLE-W. B	2000	353		10			353	17
18	REPL THERMOCOUPLE ON W.BO	2000	140		10			140	18
19	REPL THERMOCOUPLE-INDUCER	2000	215		10			215	19
20	REBUILT 2 HOPPER VALVES;R	2000	1,430		10			1,430	20
21	REPL COUPLER,MOTOR,BEARIN	2000	298		10			298	21
22	INSTALLATION OF NEW DOOR	2000	583		10			583	22
23	REPL BEARING ASSY-WATER L	2000	518		10			518	23
24	INDICATOR LAMPS & VOLTAGE	2000	1,525	38	10	38		1,525	24
25	REPLACED HEAT EXCHANGER.	2001	962	48	10	48		962	25
26	REPLACE HEAT EXCHANGER.	2001	962	56	10	56		962	26
27	REPLACE DRAFT INDUCER ON	2001	1,414	94	10	94		1,414	27
28	REPLACE PIPE.	2001	530	35	10	35		530	28
29	REPLACE CLINICAL SINK AND	2001	2,304	154	15	154		1,574	29
30	FURNISH & INSTALL AWNING.	2001	2,771	185	15	185		1,894	30
31	LABOR & MAT-BREAKER PANEL	2001	3,930	262	15	262		2,685	31
32	INSTALL THERMO COUPLE ON	2001	944	79	10	79		944	32
33	INSTALL ELECT. FOR DISHWA	2001	820	55	15	55		556	33
34	TOTAL (lines 1 thru 33)		$ 2,937,695	$ 72,000		$ 72,000	$	$ 2,050,104	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: 07/01/2010 Ending: 06/30/2011

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		$ 2,937,695	$ 72,000		$ 72,000	$	$ 2,050,104	1
2	REROOF FACILITY AND GARAG	2001	13,960	558	25	558		5,677	2
3	LUSTERBOARD SIGN	2001	515		5			515	3
4	EXCAVATION OF NEW PARKING	2001	12,415	621	20	621		6,311	4
5	RENNOVATION INSTALLMENT.	2001	63,363		5			63,363	5
6	CONCRETE FOR CANAPY & ADD	2001	2,592		5			2,592	6
7	RECONFIGURE CHANGING AREA	2001	3,393		5			3,393	7
8	REFUND-ELECTRICAL PANEL	2001	(975)		5			(975)	8
9	INSTALL WATER HEATER	2001	3,341	223	15	223		2,227	9
10	CONDUIT & WIRING FOR DOOR	2001	1,982	132	15	132		1,322	10
11	AIR CONDITIONING IN LOBBY	2001	349	35	10	35		346	11
12	EAST TUB ROOM FAN MOTOR R	2001	213	21	10	21		212	12
13	DRYER VENT REPLACED	2001	319	32	10	32		316	13
14	RECONFIGURE WANTER HEATER	2001	1,860	124	15	124		1,219	14
15	WALKWAY	2001	4,119	275	15	275		2,723	15
16	RAILING ON STAIRS TO PARK	2002	2,130	142	15	142		1,313	16
17	PRIVACY FENCE	2002	2,550	255	10	255		2,316	17
18	INSTALL TEMP CONTROL CART	2002	537	36	15	36		340	18
19	INTERNET SET-UP-WIRING CA	2002	3,061	204	15	204		1,921	19
20	MOTOR BOILER	2002	763	76	10	76		712	20
21	REPLACE METAL DOOR	2002	1,665	111	15	111		1,008	21
22	SHUTTERS	2002	820	82	10	82		745	22
23	STORM WINDOW PROJECT	2002	8,937	447	20	447		4,059	23
24	REPLACE BREAKER, BALASTS	2002	555		5			555	24
25	TENNANT ALLOWANCE TO OFFS	2002	(5,000)		5			(5,000)	25
26	NEW MOTOR ON BOILER 1	2002	962	96	10	96		866	26
27	INSTALLED HOSPITAL OUTLET	2002	2,256	226	10	226		2,012	27
28	WIRING FOR NEW TIME CLOCK	2003	634	63	10	63		523	28
29	MOTOR & COUPLER/CIRCUL PU	2003	835	83	10	83		689	29
30	SIDE SCREENS ON DT AWNING	2003	738		5			738	30
31	ANNE'S LANDSCAPING	2004	590	59	10	59		423	31
32	PARKING LOT RENOVATION	2004	3,499	350	10	350		2,353	32
33	FIRE & ELECTRIC SYSTEM (PART OF 298)	2004	435	62	7	62		429	33
34	TOTAL (lines 1 thru 33)		$ 3,071,107	$ 76,313		$ 76,313	$	$ 2,155,348	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: 07/01/2010 Ending: 06/30/2011

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		$ 3,071,107	$ 76,313		$ 76,313	$	$ 2,155,348	1
2	NEW ELECTRICAL SYSTEM (MULIT PURPOSE RM +)	2004	6,637	948	7	948		6,479	2
3	CONDUIT AND WIRE HOOKUP	2004	965	97	10	97		635	3
4	34 HEAT/SMOKE DETECTORS	2004	2,800	400	7	400		2,633	4
5	COMMERICAL DISPOSAL	2005	551	79	7	79		511	5
6	18 KICKPLATES	2005	2,215	222	10	222		1,421	6
7	HOLLOW METAL DOOR	2005	945	63	15	63		383	7
8	DAY TRAINING ADDITION	2004	346,465	11,549	30	11,549		78,917	8
9	3 ACU124PM AIR CONDITIONERS	2005	1,755	251	7	251		1,504	9
10	REPLACE COMPRESSOR IN LOBBY	2005	11,445	763	15	763		4,514	10
11	2 NEW A/C UNITS	2005	1,170	167	7	167		975	11
12	REPLACE BOOSTER PUMP/SHOWER HEAD	2005	943	94	10	94		527	12
13	REPLACE MIXING VALVE FOR HOT WATER	2005	1,168	117	10	117		662	13
14	INSTALL PULL STATION/LIGHT/SPEAKER	2005	1,434	143	10	143		824	14
15	NEW ROOF	2006	15,987	1,599	10	1,599		8,526	15
16	SPRINKLER SYSTEM-PHASE I	2006	33,165	2,211	15	2,211		11,055	16
17	WATER HEATER	2006	4,717	472	10	472		2,358	17
18	A/C UNITS FOR BEDROOMS (3)	2006	1,755	251	7	251		1,254	18
19	FIRE DOOR FOR TUB ROOM	2006	640	64	10	64		320	19
20	SPRINKLER SYSTEM-PHASE II	2006	7,920	528	15	528		2,640	20
21	SPRINKLER SYSTEM-PHASE III	2006	13,365	891	15	891		4,232	21
22	SPRINKLER SYSTEM-PHASE IV	2006	1,978	132	15	132		604	22
23	LIGHT FIXTURES (24) AND NEW WIRING	2007	6,434	429	15	429		1,894	23
24	DUCTWORK & ROOF EXHAUST FOR NEW DRYER	2007	3,498	233	15	233		1,010	24
25	BRAKE ASSEMBLY ON DUMBWAITER	2007	4,389	293	15	293		1,146	25
26	AIR CONDITIONING WINDOW UNITS (2)	2007	1,170	167	7	167		669	26
27	RAISE SIDEWALKS	2007	950	95	10	95		380	27
28	TILE WALLS IN CLASSROOMS 1-4, 8	2008	9,300	620	15	620		2,118	28
29	PRIVACY WALL IN DAY ROOMS (2)	2008	3,297	220	15	220		678	29
30	PISTONS & GEARS FOR WATER SOFTNER SYSTEM	2008	947	95	10	95		308	30
31	DOOR ASSEMLY FOR BOILER	2007	1,072	107	10	107		429	31
32	PORTIONS OF PARKING LOT REPLACED/RESURFACED	2008	3,670	367	10	367		979	32
33	A/C WALL UNITS (4)	2008	1,841	184	10	184		537	33
34	TOTAL (lines 1 thru 33)		$ 3,565,695	$ 100,162		$ 100,162	$	$ 2,296,473	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: 07/01/2010 Ending: 06/30/2011

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		$ 3,565,695	$ 100,162		$ 100,162	$	$ 2,296,473	1
2	5 TON A/C COMPRESSOR	2008	2,000	200	10	200		583	2
3	CABINETS FOR SOUTH DAY ROOM	2008	908	61	15	61		172	3
4	SMOKE DETECTORS (5)	2008	1,631	163	10	163		462	4
5	WIRING & OUTLETS FOR KITCHEN & DAYROOMS	2008	3,434	229	15	229		630	5
6	CIRCULATING PUMP FOR KITCHEN	2008	678	68	10	68		181	6
7	EXIT & BOILER ROOM DOORS REPLACED	2008	2,712	181	15	181		452	7
8	AQUASTAT REPLACED ON BOILER	2008	533	53	10	53		133	8
9	BOILER VENTILATION MOTOR DELAY SWITCH	2008	1,716	172	10	172		443	9
10	BEARINGS FOR HOT WATER CIRCULATING PUMP	2009	736	49	15	49		114	10
11	AVAYA PHONE SYSTEM FOR DAY TRAINING	2009	7,010	701	10	701		1,460	11
12	CABINETS & COUNTER FOR EDU BLDG KITCHEN	2009	1,162	77	15	77		161	12
13	HOT WATER CIRCULATION PUMP	2009	517	52	10	52		112	13
14	REMODEL EMPLOYEE/PUBLIC RESTROOMS (2)	2009	1,722	172	10	172		344	14
15	CONVERT 2 CLASSROOMS TO 1 & REMODEL RESTROOM	2009	2,846	190	15	190		380	15
16	SEWAGE PUMP	2009	4,133	413	10	413		999	16
17	ELECTRICAL OUTLETS FOR FOOD SERVICE	2009	1,419	95	15	95		189	17
18	5 TON ROOFTOP HVAC UNIT	2009	6,485	432	15	432		865	18
19	26 X 12 STORAGE SHED	2009	8,280	552	15	552		1,104	19
20	WATER HEATERS (2)	2009	11,250	1,125	10	1,125		2,156	20
21	CABINETS FOR EDUCATION BLDG	2009	562	37	15	37		72	21
22	FIRE DAMPER FOR LAUNDRY AIR INTAKE	2009	1,452	97	15	97		177	22
23	INDUCT AIR PURIFIERS (5)	2009	1,690	169	10	169		268	23
24	CONCRETE SIDEWALK FOR EMERGENCY EXIT	2009	7,119	475	15	475		910	24
25	TREX SECURITY FENCE	2009	9,142	609	15	609		1,067	25
26	RPL PARTS ON ROOFTOP RTUS	2010	1,737	174	10	174		246	26
27	SHAFT FOR BOILER EXHAUST	2010	512	51	10	51		77	27
28	BEARING ASSEMBLY FOR HOT WATER PUMP IN KITCHE	2010	522	52	10	52		65	28
29	ROOF FOR COURTYARD PAVILLION	2010	6,657	444	15	444		481	29
30	120 VOLT ELECTRICAL OUTLET FOR AIR PURIFIERS	2010	781	52	15	52		56	30
31	GREASE TRAP REPLACED AND ELECTRIC & TILE REPA	2010	7,217	481	15	481		521	31
32	STEEL ROLL-UP DOOR FOR DUMPSTER ENCLOSURE	2010	1,399	140	10	140		198	32
33	TILE WORK FOR WALLS IN SOUTH & EAST HALLS	2010	11,594	1,159	10	1,159		1,159	33
34	TOTAL (lines 1 thru 33)		$ 3,675,249	$ 109,087		$ 109,087	$	$ 2,312,710	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: 07/01/2010 Ending: 06/30/2011

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 12F, Carried Forward		$ 3,675,249	$ 109,087		$ 109,087	$	$ 2,312,710	1
2	MISC ELECTRICAL WORK	2010	4,915	246	15	246		246	2
3	MAIN DRAIN LINE REPLACED	2010	2,818	141	15	141		141	3
4	PARAPET WALL ON ROOF	2010	8,215	274	20	274		274	4
5	REMODEL PAVILLION	2010	759	76	10	76		76	5
6	GREENHOUSE FOR THERAPY USE	2010	12,475	624	10	624		624	6
7	HOT WATER CIRCULATING PUMP	2011	2,457	82	10	82		82	7
8	REMODEL RESTROOM FOR ISOLATION ROOM	2011	2,556	85	10	85		85	8
9	CONVERT DAYROOM TO CULINARY ARTS CENTER	2011	721	24	10	24		24	9
10	ELECTRIC KEYPAD DOOR OPENER	2011	598	10	10	10		10	10
11	HOT WATER MIXING VALVE	2011	1,200	10	10	10		10	11
12	TILE IN LOBBY AND SURROUNDING AREAS	2011	3,274	27	10	27		27	12
13	RENTENTION POND	2011	7,273	61	10	61		61	13
14	HARDSCAPE & LANDSCAPE FOR RENTENTION POND	2011	3,936	33	10	33		33	14
15	VINYL COATED CHAIN LINK FENCE	2011	6,475	54	10	54		54	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)		$ 3,732,922	$ 110,832		$ 110,832	$	$ 2,314,456	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: 07/01/2010 Ending: 06/30/2011

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	$ 263,092	$ 45,795	$ 45,795	$		$ 134,803	71
72	Current Year Purchases	123,184	9,955	9,955			9,955	72
73	Fully Depreciated Assets	516,325					516,325	73
74								74
75	TOTALS	$ 902,601	$ 55,750	$ 55,750	$		$ 661,083	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	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	2008	11,803	88	88			11,803	78
79	Patient Transportation	See Attached	2008 - 2010	136,649	13,751	13,751			31,461	79
80	TOTALS			$ 170,228	$ 13,839	$ 13,839	$		$ 65,040	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)	$ 5,219,836	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 180,421	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 180,421	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)	$ 3,040,579	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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				1,459			5
6								6
7	TOTAL				$ 1,459 **			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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ Description:
    (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: 07/01/2010 Ending: 06/30/2011

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 ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [X]
   - 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)		3,705		3,705
4	Clinical Wages (b)		21,403		21,403
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 25,108	$	$ 25,108
10	SUM OF line 9, col. 1 and 2 (e)	$ 25,108			

C. CONTRACTUAL INCOME

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

$ 40,532

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: 07/01/2010 Ending: 06/30/2011

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	10.1	1 hrs	$ 92		$	$	1	$ 92	1
2	Licensed Speech and Language Development Therapist	10.1	hrs		113	5,950		113	5,950	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10.1	126 hrs	6,186			476	126	6,662	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			$ 6,278	113	$ 5,950	$ 476	240	$ 12,704	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.

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2011 (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	$ 1,692	$	1
2	Cash-Patient Deposits	51,390		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,327,202		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,957		6
7	Other Prepaid Expenses	9,221		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,418,462	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	705,013		13
14	Buildings, at Historical Cost	3,219,600		14
15	Leasehold Improvements, at Historical Cost	64,666		15
16	Equipment, at Historical Cost	1,230,556		16
17	Accumulated Depreciation (book methods)	(3,040,578)		17
18	Deferred Charges	12,625,152		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	492,150		21
22	Other Long-Term Assets (specify):	257,849		22
23	Other(specify):	396,152		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 15,950,560	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 17,369,022	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 133,059	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	51,390		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	190,145		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,100		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	31,931		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Current Portion Long Term Bonds	91,258		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 511,883	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,205,222		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)**	$ 5,205,222	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,717,105	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,651,917	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 17,369,022	$	48

***(See instructions.)**

Facility Name & ID Number Exceptional Care & Training Center **#** 0035477 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 11,094,573	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 11,094,573	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	557,344	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 557,344	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)**	$ 11,651,917	24	*

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

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	$ 6,901,808	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,901,808	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	40,532	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		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 40,532	23
	D. Non-Operating Revenue		
24	Contributions	74,832	24
25	Interest and Other Investment Income***	12,714	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 87,546	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)	(5,877)	27
28	Miscellaneous Income	32,986	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 27,109	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,056,995	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	894,140	31
32	Health Care	2,201,413	32
33	General Administration	1,718,631	33
	B. Capital Expense		
34	Ownership	585,220	34
	C. Ancillary Expense		
35	Special Cost Centers	809,863	35
36	Provider Participation Fee	290,384	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,499,651	40
41	**Income before Income Taxes (line 30 minus line 40)****	557,344	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 557,344	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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: 07/01/2010 Ending: 06/30/2011

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	1,942	2,201	$ 65,601	$ 29.81	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,082	7,825	197,285	25.21	3
4	Licensed Practical Nurses	19,735	21,855	454,925	20.82	4
5	CNAs & Orderlies	81,006	88,568	1,022,426	11.54	5
6	CNA Trainees					6
7	Licensed Therapist	123	127	6,358	50.06	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,783	2,056	40,185	19.55	9
10	Activity Assistants	20,135	22,197	226,230	10.19	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,892	2,094	37,277	17.80	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,272	13,556	142,725	10.53	15
16	Dishwashers					16
17	Maintenance Workers	2,853	3,050	45,605	14.95	17
18	Housekeepers	12,822	14,377	170,867	11.88	18
19	Laundry	11,151	12,494	147,994	11.85	19
20	Administrator	2,069	2,333	103,142	44.21	20
21	Assistant Administrator					21
22	Other Administrative	5,012	5,586	97,532	17.46	22
23	Office Manager					23
24	Clerical					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 Ca Ward Clerks					32
33	Other(specify) Day Training	52,051	57,074	707,916	12.40	33
34	TOTAL (lines 1 - 33)	231,928	255,393	$ 3,466,068 *	$ 13.57	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	$ 10,441	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	2,687	10 / 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				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	6,300	9 / 3	46
47	Other Plant Operations	N/A	42,831	6 / 3	47
48	Other Administrative	N/A	2,479	21 / 3	48
49	TOTAL (lines 35 - 48)		$ 85,738		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: 07/01/2010 Ending: 06/30/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Melissa Francque	Administrator	0	$ 103,142
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 103,142

B. Administrative - Other

Description	Amount
Equipment -Small Purchase / Repair & Maint.	$ 2,152
Auto Expense	33
Taxes, License, / Resident Concern	2,073
Group Overhead	275,025
TOTAL (agree to Schedule V, line 17, col. 3)	$ 279,283
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Medical Rehabilittion Centers	Management fees	$ 446,400
BKD, LLP	Accounting Fees	5,045
Daily Gazette	Legal Fees	118
DeWitt Ross & Stevens	Legal Fees	89
Dr. Aqueel Khan	Legal Fees	1,600
Duane Morris LLP	Legal Fees	70,356
HB Wilkinson	Legal Fees	50
Marvin G Ripley	Legal Fees	131
Miller, Lancaster, Walker, Bur	Legal Fees	200
Medical Rehabilittion Centers	Legal Fees	5,077
SmithAdmunsen LLC	Legal Fees	12,056
Stites & Harbison / Taft, Setttin	Legal Fees	431
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 541,553

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 61,064
Unemployment Compensation Insurance	
FICA Taxes	263,346
Employee Health Insurance	220,517
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement Plan	5,649
Employee Benefits - Other	10,243
Corporate Allocation	49,052
TOTAL (agree to Schedule V, line 22, col.8)	$ 609,871

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	$
Advertising: Employee Recruitment	3,546
Health Care Worker Background Check	
(Indicate # of checks performed)	1,720
Patient Background Checks	
Activity Connection	143
Clement Communications	256
Illinois Health Care Association	4,637
Thompson West	3,059
Corporate Allocation	45,320
Less: Public Relations Expense	(1,522)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 57,159

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Conference for CEUs	(324)
	15
In-State Travel	
Regional & Corporate Travel	8,806
Meals & Entertainment	929
Seminar Expense	
Silverchair Learning	3,420
Health Educators/Policy Tech	366
WorldPoint/MDI Achieve/Other	1,038
Entertainment Expense	(929)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,321

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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			$		$	$	$	$	$	$	$	$	$
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: 07/01/2010 Ending: 06/30/2011

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. **Illinois Health Care Association $6,565**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **0** Line

(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.

(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 fo
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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **290,384**
This amount is to be recorded on line 42 of Schedule V.

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

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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 fo
residents? If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all othe
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. $

(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 ou
out of Schedule V? **Yes**

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

Exceptional Care Training Center
Schedule of Reclassifications
FYE 06/30/2011

Account	Description	Reclassifications Increase	Reclassifications Decrease	Sche X Line #
61200	Inservice Seminars		7.95	24
61300	Inservice Seminars	7.95		20
61945	CNA Training -Classroom	3,704.40		13
61945	CNA Training -Clinical	21,403.30		13
61945	CNA Training -Classroom		3,704.40	10
61945	CNA Training -Clinical		21,403.20	10
	Totals	25,115.65	25,115.55	

Exceptional Care Training Center
Schedule V Line 24
FYE 06/30/2011

Dept	Job	Account	Reference	Description	Amount	Page	Line	Col
6160	00000	61200	61600000061200	Inservice, Seminars, Etc.	4,824	3	24	3
6160	00000	61210	61600000061210	Travel	8,814	3	24	3
6160	00000	61222	61600000061222	Meals & Entertainment	929	3	24	3
				Total Line 24	14,567			

Exceptional Care Training Center
Schedule V Line 27
FYE 06/30/2011

Dept	Job	Account	Reference	Description	Amount	Page	Line	Col
5000	00000	58000	50000000058000	Contributions Fund Expense	72	3	27	3
9000	00000	90900	90000000090900	Rounding	(6)	3	27	3
				Total Line 27	66			

Exceptional Care Training Center
Schedule V Line 43
FYE 06/30/2011

Dept	Job	Account	Reference	Description	Amount	Page	Line	Col
6020	30100	61941	60203010061941	Overtime Wages	15	4	43	1
6020	30110	61941	60203011061941	Overtime Wages	447	4	43	1
6020	30120	61941	60203012061941	Overtime Wages	31	4	43	1
6020	30110	61942	60203011061942	Sick Time/Leave Reserve	2,244	4	43	1
6020	30120	61942	60203012061942	Sick Time/Leave Reserve	158	4	43	1
6020	30110	61943	60203011061943	Premium Pay Wages	7,343	4	43	1
6020	30100	61944	60203010061944	Paid Time Off Wages	2,093	4	43	1
6020	30110	61944	60203011061944	Paid Time Off Wages	46,185	4	43	1
6020	30120	61944	60203012061944	Paid Time Off Wages	8,857	4	43	1
6020	30100	61945	60203010061945	Salaries & Wages	40,958	4	43	1
6020	30110	61945	60203011061945	Salaries & Wages	488,146	4	43	1
6020	30120	61945	60203012061945	Salaries & Wages	111,439	4	43	1
6020	00000	61031	60200000061031	Supplies - Other	6,283	4	43	2
6020	00000	61018	60200000061018	Contract Services - Other	2,576	4	43	3
6020	00000	61021	60200000061021	Equipment - Small Purchase	323	4	43	3
6020	00000	61022	60200000061022	Equipment - Repairs & Main	65	4	43	3
6020	00000	61140	60200000061140	Rent - Building	81,420	4	43	3
6020	00000	61162	60200000061162	Utilities - Electricity	6,426	4	43	3
6020	00000	61163	60200000061163	Utilities - Gas	3,853	4	43	3
6020	00000	61165	60200000061165	Utilities - Water & Sewer	1,001	4	43	3
				Total Line 43	809,863			