FOR BHF USE

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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 C & Training Ctr

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: 08/15/1989

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: Joe Guillory **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 07/01/2014 to 06/30/2015 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) 09/30/15 (Date)
(Type or Print Name) Joseph Guillory
(Title) Designated Agent

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) 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 C & Training Ctr # 0035477 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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 No Change

	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	29,982			29,982	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,982			29,982	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.79%

D. How many bed-hold days during this year were paid by the Department?
_____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None.

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

I. On what date did you start providing long term care at this location?
Date started 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 N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: FYE 6/30/2015 Fiscal Year: FYE 6/30/2015

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

Facility Name & ID Number Exceptional C & Training Ctr # 0035477 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	168,753	9,107	14,477	192,337		192,337	(28,539)	163,798			1
2	Food Purchase		170,754		170,754		170,754	(25,336)	145,418			2
3	Housekeeping	148,556	15,354		163,910		163,910	(24,321)	139,589			3
4	Laundry	149,422	13,476	1,967	164,865		164,865	(24,462)	140,403			4
5	Heat and Other Utilities			80,797	80,797		80,797		80,797			5
6	Maintenance	42,619	16,862	41,231	100,712	313	101,025	(46)	100,979			6
7	Other (specify):*											7
8	TOTAL General Services	509,350	225,553	138,472	873,375	313	873,688	(102,704)	770,984			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	1,742,116	155,635	15,986	1,913,737		1,913,737	(283,956)	1,629,781			10
10a	Therapy	6,751	704	7,660	15,115		15,115	(2,243)	12,872			10a
11	Activities	247,162	2,049	240	249,451		249,451		249,451			11
12	Social Services		55		55		55		55			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,996,029	158,443	44,886	2,199,358		2,199,358	(286,199)	1,913,159			16
	C. General Administration											
17	Administrative	121,152		113,340	234,492	170,563	405,055	(107,030)	298,025			17
18	Directors Fees											18
19	Professional Services			547,835	547,835	(280,954)	266,881	(281,018)	(14,137)			19
20	Dues, Fees, Subscriptions & Promotions			45,005	45,005	17,451	62,456	(33,492)	28,964			20
21	Clerical & General Office Expenses	67,054	19,430	42,962	129,446	16,910	146,356	(44,181)	102,175			21
22	Employee Benefits & Payroll Taxes			502,599	502,599	29,467	532,066	(64,133)	467,933			22
23	Inservice Training & Education			15,045	15,045	720	15,765	(3,220)	12,545			23
24	Travel and Seminar			5,302	5,302	25,041	30,343	(4,733)	25,610			24
25	Other Admin. Staff Transportation			278	278		278		278			25
26	Insurance-Prop.Liab.Malpractice			17,494	17,494	2,757	20,251	21,414	41,665			26
27	Other (specify):* Indigent Care			2,643	2,643		2,643	(2,643)				27
28	TOTAL General Administration	188,206	19,430	1,292,503	1,500,139	(18,045)	1,482,094	(519,036)	963,058			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,693,585	403,426	1,475,861	4,572,872	(17,732)	4,555,140	(907,939)	3,647,201			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 C & Training Ctr #0035477 **Report Period Beginning:** 07/01/2014 **Ending:** 06/30/2015

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					5,026	5,026	196,999	202,025			30
31	Amortization of Pre-Op. & Org.											31
32	Interest					3,436	3,436	167,446	170,882			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			499,309	499,309	8,738	508,047	(500,606)	7,441			34
35	Rent-Equipment & Vehicles			6,052	6,052	532	6,584	(79)	6,505			35
36	Other (specify):* **Mortgage Ins**							31,816	31,816			36
37	**TOTAL Ownership**			505,361	505,361	17,732	523,093	(104,424)	418,669			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	669,536	9,133	164,833	843,502		843,502	(843,502)				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			312,208	312,208		312,208		312,208			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	669,536	9,133	477,041	1,155,710		1,155,710	(843,502)	312,208			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,363,121	412,559	2,458,263	6,233,943		6,233,943	(1,855,865)	4,378,078			45

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

STATE OF ILLINOIS

Facility Name & ID Number	Exceptional C & Training Ctr	#	#0035477	Report Period Beginning:	07/01/2014	Ending:

Exceptional Care & Training Center
Schedule V Supplemental Schedule
Reclassifications

DESCRIPTION	INCREASE / (DECREASE)	SCH V LINE.COL
1 Reclassification of Hoosier Care Group Expenses:		
Administrative (Rel. Party Group Expense Allocatior	(77,981)	17.5
Administration	58,851	17.5
Dues, Fees, Subscriptions & Promotions	15,654	20.5
Clerical & General Office Expenses	40	21.5
Interest	3,436	32.5
2 Reclassification of ELC Corporate Expenses		
Professional Services (Rel. Party Mgmt. Fee)	(294,989)	19.5
Maintenance	313	6.5
Administrative	189,693	17.5
Professional Services	14,035	19.5
Dues, Fees, Subscriptions & Promotions	1,797	20.5
Clerical & General Office Expenses	16,870	21.5
Employee Benefits & Payroll Taxes	29,467	22.5
Inservice Training & Education	720	23.5
Travel & Seminar	25,041	24.5
Insurance - Prop.Liab.Malpractice	2,757	26.5
Depreciation	5,026	30.5
Interest	-	32.5
Rent - Facility & Grounds	8,738	34.5
Rent - Equipment	532	35.5

STATE OF ILLINOIS

Facility Name & ID Number	Exceptional C & Training Ctr	#	#0035477	Report Period Beginning:	07/01/2014	Ending:

Exceptional C & Training Ctr
Schedule V - Line 23 Detailed Schedule

	Purpose of Seminar	Name of Attendee	Title of Attendee	Exp Amount
	Silverchair Learning Systems Core Curriculum Education Software Quarterly Bill - billing for July - September			2,779
	Fall 2014 IANFP Workshop CLASSES: Job Descriptions; Employee Training; Swallow Evals; Gluten Free Experience	Sheila Hamilton	Food Services Director	55
	Wessels Sherman TRAINING: Warp Speed Compliance Training for Employes, Managers and Supervisors	Melissa Francque	Executive Director	100
	IL Health Care Association ID/DD Symposium 2015	Melissa Francque	Executive Director	125
	IL Health Care Association WEB SEMINAR: POLST is More Than a Form It's a Process	Melissa Franque	Executive Director	75
	Reg III ADA	Sue Martinez	Activity Director	50
A	FSSMC Class	Jamie Richards	Cook	145
A	Altorfer Inc. Training Engine and Generator	Danny Webber	Maintenance Director	160
	IL Health Care Association WEB SEMINAR: POLST is More Than a Form It's a Process	Gwenda Justice	Director of Nursing	75
	Silverchair Learning Systems Core Curriculum Education Software Quarterly Bill - billing for October - December			2,779

A	Rudolph K. Muzzarelli HFS Driver Safety Training			500
	Silverchair Learning Systems Core Curriculum Education Software Quarterly Bill - billing for January - March			2,863
	Omnicare Essentials of Infusion Therapy	Various Employees		1,350
	Omnicare Essentials of Infusion Therapy	Various Employees		1,050
	Silverchair Learning Systems Core Curriculum Education Software Quarterly Bill - billing for April - June			2,863
A	Allocated Regional Support Costs			76

Line 23 Column 4 Total:	**15,045**
Line 23 Column 5 Reclassification - Corporate/Home Office Allocated Costs:	720
Line 23 Column 6 Total:	**15,765**
Unallowable Amounts above removed through SCH 5 Adjustments:	
A Non-care related amounts noted above:	(881)
Allocation for non-care-related Education and Day Training (See Pg 11.2 & 5A)	(2,339)
Line 23 Column 8 Total:	**12,545**
	0

Facility Name & ID Number Exceptional C & Training Ctr # 0035477 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	(835,099)	39		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				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	(4,447)	20		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,731)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,643)	27		24
25	Fund Raising, Advertising and Promotional	(17,971)	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	(766,698)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,628,589)		$	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)	(227,276)	17, 19	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (227,276)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,855,865)		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

STATE OF ILLINOIS **Page 5A**

Exceptional C & Training Ctr

ID# 0035477

Report Period Beginning: 07/01/2014

Ending: 06/30/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Income Offset - Contributions Received	$ (22,465)	21	1
2	Unallowable Depr Exp (below threshold, non-cap)	(81,342)	30	2
3	Unallowable Lobbying Portion of ILHCA Dues	(1,838)	20	3
4	Unallowable Ancillary Services - Rx	(8,403)	39	4
5	Unallowable Portion of Inservice Training/Edu	(881)	23	5
6	Unallowable Portion of Travel/Seminar	(230)	24	6
7				7
8	Unallowable Day Trng Alloc - Dietary	(28,539)	1	8
9	Unallowable Day Trng Alloc - Food	(25,336)	2	9
10	Unallowable Day Trng Alloc - Hskpg	(24,321)	3	10
11	Unallowable Day Trng Alloc - Laundry	(24,462)	4	11
12	Unallowable Day Trng Alloc - Nursing	(283,956)	10	12
13	Unallowable Day Trng Alloc - Therapy	(2,243)	10a	13
14	Unallowable Day Trng Alloc - Activities	0	11	14
15	Unallowable Day Trng Admin Alloc	(71,671)	17	15
16	Unallowable Day Trng Prof Svcs Alloc	(83,369)	19	16
17	Unallowable Day Trng Dues/Fees Alloc	(9,268)	20	17
18	Unallowable Day Trng Clerical Alloc	(21,716)	21	18
19	Unallowable Day Trng EE Ben Alloc	(64,133)	22	19
20	Unallowable Day Trng Insrv/Trn Alloc	(2,339)	23	20
21	Unallowable Day Trng Travel/Seminar Alloc	(4,503)	24	21
22	Unallowable Day Trng Insur Alloc	(3,005)	26	22
23	Unallowable Day Trng Maint Alloc	(46)	6	23
24	Unallowable Day Trng Depr Alloc	(746)	30	24
25	Unallowable Day Trng Int Alloc	(510)	32	25
26	Unallowable Day Trng Rent Alloc	(1,297)	34	26
27	Unallowable Day Trng Rent Alloc	(79)	35	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**	(766,698)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Exceptional C & Training Ctr **#** 0035477 **Report Period Beginning:** 07/01/2014 **Ending:** 06/30/2015

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	(28,539)	0	0	0	0	0	0	0	0	0	0	(28,539)	1
2	Food Purchase	(25,336)	0	0	0	0	0	0	0	0	0	0	(25,336)	2
3	Housekeeping	(24,321)	0	0	0	0	0	0	0	0	0	0	(24,321)	3
4	Laundry	(24,462)	0	0	0	0	0	0	0	0	0	0	(24,462)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(46)	0	0	0	0	0	0	0	0	0	0	(46)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(102,704)	0	0	0	0	0	0	0	0	0	0	(102,704)	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	(283,956)	0	0	0	0	0	0	0	0	0	0	(283,956)	10
10a	Therapy	(2,243)	0	0	0	0	0	0	0	0	0	0	(2,243)	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**	(286,199)	0	0	0	0	0	0	0	0	0	0	(286,199)	16
	C. General Administration													
17	Administrative	(71,671)	(35,359)	0	0	0	0	0	0	0	0	0	(107,030)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(85,100)	(207,811)	11,893	0	0	0	0	0	0	0	0	(281,018)	19
20	Fees, Subscriptions & Promotions	(33,524)	0	32	0	0	0	0	0	0	0	0	(33,492)	20
21	Clerical & General Office Expenses	(44,181)	0	0	0	0	0	0	0	0	0	0	(44,181)	21
22	Employee Benefits & Payroll Taxes	(64,133)	0	0	0	0	0	0	0	0	0	0	(64,133)	22
23	Inservice Training & Education	(3,220)	0	0	0	0	0	0	0	0	0	0	(3,220)	23
24	Travel and Seminar	(4,733)	0	0	0	0	0	0	0	0	0	0	(4,733)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(3,005)	0	24,419	0	0	0	0	0	0	0	0	21,414	26
27	Other (specify):*	(2,643)	0	0	0	0	0	0	0	0	0	0	(2,643)	27
28	**TOTAL General Administration**	(312,210)	(243,170)	36,344	0	0	0	0	0	0	0	0	(519,036)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(701,113)	(243,170)	36,344	0	0	0	0	0	0	0	0	(907,939)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Exceptional C & Training Ctr # 0035477 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(82,088)	0	279,087	0	0	0	0	0	0	0	0	196,999	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(510)	0	167,956	0	0	0	0	0	0	0	0	167,446	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(1,297)	0	(499,309)	0	0	0	0	0	0	0	0	(500,606)	34
35	Rent-Equipment & Vehicles	(79)	0	0	0	0	0	0	0	0	0	0	(79)	35
36	Other (specify):*	0	0	31,816	0	0	0	0	0	0	0	0	31,816	36
37	TOTAL Ownership	(83,974)	0	(20,450)	0	0	0	0	0	0	0	0	(104,424)	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	(843,502)	0	0	0	0	0	0	0	0	0	0	(843,502)	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	(843,502)	0	0	0	0	0	0	0	0	0	0	(843,502)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,628,589)	(243,170)	15,894	0	0	0	0	0	0	0	0	(1,855,865)	45

Facility Name & ID Number Exceptional C & Training Ctr # 0035477 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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
Hoosier Care, Inc.	100	Walter Lawson Children's Home	Loves Park, IL	Medical Rehabilitation	Lexington, KY	Mgmt Co.
		Swann Special Care Center	Champaign, IL	Hoosier Care Investme	Nashville, TN	NFP Affiliated Co.
		Vernon Manor Children's Home	Wabash, IN	Sterling Facility Comp	Sterling, IL	Property Co.
		Richland-Bean Blossom Health Care Center	Ellettsville, IN			
		Exceptional Living Centers of Brazil	Brazil, IN			
		Randolph Nursing Home	Winchester, IN			

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 Group Overhead	$ 113,340	Hoosier Care, Inc.	100.00%	$ 77,981	$ (35,359)	1
2	V				Note: See Schedule VIII for Allocation of Col. 7 amt and				2
3	V				reclassification to functional expense lines on Schedule V.				3
4	V								4
5	V	19	Rel. Party Management Fee	502,800	Medical Rehabilitation Centers, LLC	37.50%	294,989	(207,811)	5
6	V				dba Exceptional Living Centers				6
7	V				Hoosier Care owns a beneficial interest in MRC				7
8	V				Note: Please see Schedule VIII for Allocation of Col. 7 amt				8
9	V				and reclassification to functional expense lines on Sch V.				9
10	V								10
11	V		PLEASE SEE DISCLOSURE AND DETAIL OF ADJUSTMENTS CONTINUED ON THE NEXT PAGE (6A):						11
12	V								12
13	V								13
14	Total			$ 616,140			$ 372,970	$ * (243,170)	14

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

Facility Name & ID Number Exceptional C & Training Ctr # 0035477 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rel. Party Bldg/Equip Rent	$ 499,309	Sterling Facility Company, LLC	100.00%	$	$ (499,309)	15
16	V				This facility company is under 100% common				16
17	V				ownership with ECTC, and therefore the "rent" paid				17
18	V				to the facility company has been removed from this report,				18
19	V				and the actual expenses of the facility company have been				19
20	V				added here:.				20
21	V	30	Actual Depreciation of Rel Pty		-Depreciation		279,087	279,087	21
22	V	32	Actual Interest of Rel Pty		-Interest (net of interest income)		161,495	161,495	22
23	V	32	Actual Amort of Debt Cost-Rel Pty		-Amort of Debt Costs		6,461	6,461	23
24	V	26	Actual Insurance of Rel Pty		-Insurance		24,419	24,419	24
25	V	36	Actual Mortgage Ins of Rel Pty		-Mortgage Insurance		31,816	31,816	25
26	V	19	Actual Accting Fees of Rel Pty		-Accounting Fees		11,893	11,893	26
27	V	20	Actual Bank Fees of Rel Pty		-Bank Fees		32	32	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 499,309			$ 515,203	$ * 15,894	39

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

Facility Name & ID Number Exceptional C & Training Ctr # 0035477 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	John Foos	Board Member	Governance	0%					$		1
2	John Gillmor	Board Member	Governance	0%							2
3	Bruce Hutson	Board Member	Governance	0%							3
4	Jo Anne Corbitt	Board Member	Governance	0%							4
5	Douglas Smith	Board Member	Governance	0%							5
6	Stephen Wood	Board Member	Governance	0%							6
7	NOTE: Fees are paid by ECTC (through the Hoosier Care, Inc. group/home cost center detailed on Pg 8) to Hoosier Care Investments, LLC ("HCI"; an affiliated not-for-										7
8	which go toward, among other things solely within the control of HCI, fees for members of the Boards of Directors of HCI affiliated facilities, Exceptional Care &										8
9	Training Center being one of many. Therefore no Board Fees or compensation are paid directly by, or known to ECTC, but rather the fees paid by HoosierCare to HCI ar										9
10	combined with similar fees paid by other facilities, for HCI to provide governance and managerial oversight, including payment by HCI to Board members of each legal										10
11	entity. Fees paid by other facilities, if known, are shown on Page 7.1; The entire amount of fees included on this report, grouped on Line 17, is disclosed here:										11
12								ADMIN FEES	58,852	17.8	12
13								TOTAL	$ 58,852		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

VII. RELATED PARTIES (continued)

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

*** 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.**

Net allowable amounts paid for Home Office Administration Fees by other Nursing Homes

Walter Lawson Children's Home	77,783	Illinois
Swann Special Care Center	94,719	Illinois
Exceptional Care & Training Center	58,852	Illinois
Vernon Manor Children's Home	56,879	Indiana
Exceptional Living Center of Brazil	70,405	Indiana
Richland-Bean Blossom Health Care	54,005	Indiana
Randolph Nursing Home	52,856	Indiana

Net allowable Related Party Management Fees paid by other Nursing Homes

Walter Lawson Children's Home	389,883	Illinois
Swann Special Care Center	474,774	Illinois
Exceptional Care & Training Center	294,989	Illinois
Vernon Manor Children's Home	285,100	Indiana
Exceptional Living Center of Brazil	352,897	Indiana
Richland-Bean Blossom Health Care	270,693	Indiana
Randolph Nursing Home	264,935	Indiana

Facility Name & ID Number Exceptional C & Training Ctr # 0035477 Report Period Beginning: 07/01/2014 Ending: 6/30/2015

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: 1050 Chinoe Road, Suite 350
City / State / Zip Code: Lexington, KY 40502
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	17	Administrative	Direct Cost	42,718,084	7	$ 465,496	$ 0	5,400,731	$ 58,851	1
2	20	Dues, Fees, Subscriptions & Prom	Direct Cost	42,718,084	7	123,820	0	5,400,731	15,654	2
3	21	Clerical & General Office Expens	Direct Cost	42,718,084	7	316	0	5,400,731	40	3
4	32	Interest	Direct Cost	42,718,084	7	27,175	0	5,400,731	3,436	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 616,807	$		$ 77,981	25

Facility Name & ID Number Exceptional C & Training Ctr # 0035477 Report Period Beginning: 07/01/2014 Ending: 6/30/2015

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: Medical Rehabilitation Centers, LLC, dba Except
Street Address: 1050 Chinoe Road, Suite 350
City / State / Zip Code: Lexington, KY 40502
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	6	Maintenance	Direct Costs	82,824,020	15	$ 4,803	$	5,400,731	$ 313	1
2	17	Administrative	Direct Costs	82,824,020	15	2,909,082	2,849,135	5,400,731	189,693	2
3	19	Professional Services	Direct Costs	82,824,020	15	215,236		5,400,731	14,035	3
4	20	Dues, Fees, Subscriptions	Direct Costs	82,824,020	15	27,556		5,400,731	1,797	4
5	21	Clerical & General Office	Direct Costs	82,824,020	15	258,716		5,400,731	16,870	5
6	22	Employee Benefits & Payroll Tax	Direct Costs	82,824,020	15	451,890		5,400,731	29,467	6
7	23	Inservice Training & Education	Direct Costs	82,824,020	15	11,045		5,400,731	720	7
8	24	Travel & Seminar	Direct Costs	82,824,020	15	384,026		5,400,731	25,041	8
9	26	Insurance	Direct Costs	82,824,020	15	42,282		5,400,731	2,757	9
10	30	Depreciation	Direct Costs	82,824,020	15	77,083		5,400,731	5,026	10
11	32	Interest	Direct Costs	82,824,020	15			5,400,731		11
12	34	Rent - Facility & Grounds	Direct Costs	82,824,020	15	133,999		5,400,731	8,738	12
13	35	Rent - Equipment	Direct Costs	82,824,020	15	8,152		5,400,731	532	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					$ 4,523,870	$ 2,849,135		$ 294,989	25

Facility Name & ID Number Exceptional C & Training Ctr # 0035477 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	LP Mortgage HUD Loan		X	Facility Purchase Financing	$26,513.35	11/1/12	$ 6,675,000	$ 6,291,830	11/1/42	0.0254	$ 161,639	1
2												2
3												3
4												4
5												5
	Working Capital											
6	GE Healthcare Finance		X	Working Capital	$0.00	10/27/11	5,000,000	$0.00	10/27/14	Variable	$0.00	6
7	GE Healthcare Finance		X	Working Capital	$0.00	06/24/14	5,750,000	$0.00	10/27/19	Variable	$0.00	7
8												8
9	TOTAL Facility Related				$26,513.35		$ 17,425,000	$ 6,291,830			$ 161,639	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 17,425,000	$ 6,291,830			$ 161,639	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 31,816** **Line #** **36**

*** 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 C & Training Ctr **#** 0035477 **Report Period Beginning:** 07/01/2014 **Ending:** 06/30/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 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 2015 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:			
	2010		8
	2011		9
	2012		10
	2013		11
	2014		12

Note: This facility became exempt from Property Taxes starting on 1/1/1996.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Exceptional C & Training Ctr COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0035477

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(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 _____ 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 C & Training Ctr # 0035477 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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

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

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (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).

ECTC Developmental Day Training Program, operated offsite; cost removal adjustments & allocation to remove associated costs shown on SCH V; See Pg 11.2 for further detai

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

Exceptional C & Training Ctr
Schedule X Supplemental Schedule
Item 14 - Allocation of non-long term care costs

(E) Exceptional Care & Training Center operates a Developmental Day Training program in dedicated space offsite from the skilled nursing facility. All costs specifically attributable to this programs in dedicated GL accounts, including wages/salaries, supplies, rent and occupancy costs, have been grouped in line 39 of Schedule V, "Ancillary Service Centers", and are removed via adjustment on Schedule VI, Line 3.
In addition, a portion of all other cost centers and expense items which provide benefits and support to the Day Training program are removed via adjustment on Schedule VI, Line 29. The following allocation methodology is utilized:

The percentage of costs identified for each program are utilized to allocate other non-specific/overhead/administrative items attributable to Day Training, and such identified and allocated costs are removed in this Cost Report. A percentage of wages and salaries expense, identifiable to each specific program and position, is utilized to allocate Employee benefits (payroll taxes area already tracked and removed separately). Hours of operation of each program are utilized to allocate administrative, overhead, and support services.

The results of these allocations appear on Schedule VI, as adjustments to remove shared costs attributable to non-long term care services.

Facility Name & ID Number Exceptional C & Training Ctr # 0035477 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	$	$ 1,807,166	4
5	15			1991	358,311	11,944	30	11,944		287,207	5
6	5			2004							6
7											7
8											8
	Improvement Type**										
9	REPLACE WATER UNIT			6/27/1991	8,780.00	-	10-0			8,780.00	9
10	REPLACE HEAT EXCHANGER-SC			2/3/1992	4,061.99	-	10-0			4,061.99	10
11	BOILER TUBES - SCHMIDT PL			3/4/1992	7,146.73	-	10-0			7,146.73	11
12	ROOF - HAUS BLDRS			3/19/1992	11,117.91	-	10-0			11,117.91	12
13	KITCHEN TILE SCHMIDT & AS			4/20/1992	3,660.10	-	10-0			3,660.10	13
14	HEATING & COOLING UNIT SC			6/29/1992	7,757.00	-	10-0			7,757.00	14
15	LIGHT FIXTURES			7/1/1992	3,743.09	-	10-0			3,743.09	15
16	ELECTRICAL WORK			4/23/1993	3,255.48	-	10-0			3,255.48	16
17	TILE FOR FLOORS IN TUB RO			2/16/1995	4,405.00	-	10-0			4,405.00	17
18	THERMOCOUPLE ON BOILER			3/8/1995	2,550.17	-	10-0			2,550.17	18
19	REPLACE FIRE ALARM			6/30/1995	3,743.32	-	10-0			3,743.32	19
20	PART:GENERATOR,TRANSFER S			9/11/1998	2,746.49	-	10-0			2,746.49	20
21	INSTALL TILE:WALLS,STAIRC			12/2/1998	4,495.00	-	10-0			4,495.00	21
22	2 HOT WATER TANKS			3/5/1999	7,119.35	-	10-0			7,119.35	22
23	COOLING SYSTEM-LAUNDRY/KI			1/22/2000	4,650.00	232.50	20-0	233		3,603.96	23
24	NEW TILE IN DINING RM/CLA			4/11/2000	4,770.00	238.50	15-0	239		4,770.00	24
25	FURNISH & INSTALL AWNING.			4/6/2001	2,771.26	184.75	15-0	185		2,632.80	25
26	LABOR & MAT-BREAKER PANEL			4/12/2001	3,930.00	262.00	15-0	262		3,733.41	26
27	INSTALL WATER HEATER			7/5/2001	3,341.20	222.75	15-0	223		3,118.44	27
28	INTERNET SET-UP-WIRING CA			2/21/2002	3,060.62	204.04	15-0	204		2,737.48	28
29	STORM WINDOW PROJECT			6/24/2002	8,937.00	446.85	20-0	447		5,846.32	29
30	New Electrical System (Mulit Purpose Rm			9/9/2004	6,637.40	-	7-0			6,637.40	30
31	34 heat/smoke detectors			12/2/2004	2,800.00	-	7-0			2,800.00	31
32	replace compressor in lobby			8/9/2005	11,445.00	763.00	15-0	763		7,566.42	32
33	Water heater			6/16/2006	4,716.60	471.66	10-0	472		4,244.94	33
34	Sprinkler system-Phase I			6/30/2006	33,165.00	2,211.00	15-0	2,211		19,899.00	34
35	Sprinkler system-Phase II			6/30/2006	7,920.00	528.00	15-0	528		4,752.00	35
36	Sprinkler system-Phase III			9/21/2006	13,365.00	891.00	15-0	891		7,796.25	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 C & Training Ctr # 0035477 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	Light fixtures (24) and new wiring	1/22/2007	$ 6,433.74	$ 428.92	15-0	$ 429	$	$ 3,610.08	37
38	Ductwork & roof exhaust for new dryer	3/15/2007	3,497.88	233.19	15-0	233		1,943.25	38
39	Brake assembly on dumbwaiter	7/24/2007	4,389.00	292.60	15-0	293		2,316.42	39
40	Tile walls in classrooms 1-4, 8	1/22/2008	9,300.00	620.00	15-0	620		4,598.33	40
41	Privacy wall in day rooms (2)	6/6/2008	3,297.37	219.82	15-0	220		1,557.06	41
42	Wiring & outlets for kitchen & dayrooms	9/26/2008	3,434.00	228.93	15-0	229		1,545.28	42
43	Exit & boiler room doors replaced	12/18/2008	2,711.50	180.77	15-0	181		1,175.00	43
44	Avaya phone system for day training	5/21/2009	7,010.00	701.00	10-0	701		4,264.42	44
45	5 ton rooftop hvac unit	7/9/2009	6,485.00	432.33	15-0	432		2,593.98	45
46	26 x 12 storage shed	7/12/2009	8,280.00	552.00	15-0	552		3,312.00	46
47	Water heaters (2)	8/13/2009	11,250.00	1,125.00	10-0	1,125		6,656.25	47
48	Grease trap replaced and electric & tile	5/20/2010	7,217.12	481.14	15-0	481		2,445.80	48
49	Roof for courtyard pavillion	5/28/2010	6,657.00	443.80	15-0	444		2,255.98	49
50	Tile work for walls in south & east hall	7/15/2010	11,593.55	1,159.36	10-0	1,159		5,796.80	50
51	Misc electrical work	10/6/2010	4,915.00	327.67	15-0	328		1,556.43	51
52	Main drain line replaced	10/9/2010	2,818.05	187.87	15-0	188		892.38	52
53	Parapet wall on roof	10/28/2010	8,215.00	410.75	20-0	411		1,916.83	53
54	Remodel restroom for isolation room	2/28/2011	2,556.18	255.62	10-0	256		1,107.69	54
55	Tile in lobby and surrounding areas	6/14/2011	3,274.25	327.43	10-0	327		1,337.01	55
56	Roof hvac units (2)	10/3/2011	8,173.00	817.30	10-0	817		3,064.88	56
57	Water heater for south wing	10/4/2011	7,936.94	793.69	10-0	794		2,976.34	57
58	Replace header on basement door	12/7/2011	4,870.21	324.68	15-0	325		1,163.44	58
59	Medical room remodel	12/1/2012	8,081.62	808.16	10-0	808		2,087.75	59
60	Boiler	3/1/2013	22,524.83	1,501.66	15-0	1,502		3,503.87	60
61	Bryant a/c units (2) and dishwasher hood	4/12/2013	13,875.00	925.00	15-0	925		2,081.25	61
62	Boiler Repair/Replacement	7/23/2013	29,683.28	2,968.33	10-0	2,968		5,689.30	62
63	Nurses Station Remodel	8/15/2013	19,747.00	1,974.70	10-0	1,975		3,784.84	63
64	Nurses Station Remodel	10/2/2013	19,748.00	1,974.80	10-0	1,975		3,455.90	64
65	Replaced Fire Door	10/3/2013	5,615.00	561.50	10-0	562		982.63	65
66	New Dumbwaiter	12/20/2013	10,898.00	1,089.80	10-0	1,090		1,634.70	66
67	Installation of dumbwaiter	4/10/2014	21,797.00	2,179.70	10-0	2,180		2,724.63	67
68	New Tile	6/12/2014	2,578.41	257.84	10-0	258		279.33	68
69	Emergency Generator	7/31/2014	10,775.00	987.71	10-0	988		987.71	69
70	**TOTAL (lines 4 thru 69)**		**$ 3,178,040**	**$ 102,373**		**$ 102,373**	**$**	**$ 2,334,390**	70

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

Facility Name & ID Number Exceptional C & Training Ctr # 0035477 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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**		$ 3,178,040	$ 102,373		$ 102,373	$	$ 2,334,390	1
2	Emergency Generator	7/31/2014	10,775.00	987.71	10-0	988		987.71	2
3	Emergency Generator	7/31/2014	12,810.00	1,174.25	10-0	1,174		1,174.25	3
4	Replace Dry Wall in 3 Rooms	11/7/2014	2,950.00	196.67	10-0	197		196.67	4
5	New Metal Doors	11/19/2014	5,635.00	328.71	10-0	329		328.71	5
6	Replaced Drain Line in Kitchen	11/19/2014	2,700.04	157.50	10-0	158		157.50	6
7	3 Bathroom Remodels	12/10/2014	4,185.00	244.13	10-0	244		244.13	7
8	New Roof	12/30/2014	4,391.16	219.56	10-0	220		219.56	8
9	New Roof	12/30/2014	7,350.00	367.50	10-0	368		367.50	9
10	New Roof	12/30/2014	6,000.00	300.00	10-0	300		300.00	10
11	Installed FRP Board in Several areas	3/19/2015	3,010.00	75.25	10-0	75		75.25	11
12	GATE & FENCE SCARS	5/29/1992	4,038.00	-	10-0			4,038.00	12
13	NEW WATER MAIN	10/11/1993	12,203.63	-	10-0			12,203.63	13
14	RESEAL PARKING AREA	6/7/1997	2,845.00	-	10-0			2,845.00	14
15	TANK REPLACEMENT - PIPECO	9/28/1998	9,890.00	494.50	20-0	495		8,324.18	15
16	EXCAVATION OF NEW PARKING	5/11/2001	12,415.00	620.75	20-0	621		8,793.98	16
17	WALKWAY	8/28/2001	4,119.05	274.60	15-0	275		3,821.44	17
18	PRIVACY FENCE	6/20/2002	2,550.00	-	10-0			2,550.00	18
19	Parking Lot Renovation	9/11/2004	3,499.00	95.82	10-0	96		3,499.00	19
20	Portions of parking lot replaced/resurfa	10/20/2008	3,670.00	367.00	10-0	367		2,446.67	20
21	Concrete sidewalk for emergency exit	7/26/2009	7,119.00	474.60	15-0	475		2,808.05	21
22	Trex security fence	9/28/2009	9,142.00	609.47	15-0	609		3,504.45	22
23	Greenhouse for therapy use	12/22/2010	12,474.83	1,247.48	10-0	1,247		5,613.66	23
24	Rentention pond	6/6/2011	7,273.10	727.31	10-0	727		2,969.85	24
25	Hardscape & landscape for rentention pon	6/6/2011	3,936.00	393.60	10-0	394		1,607.20	25
26	Vinyl coated chain link fence	6/7/2011	6,475.00	647.50	10-0	648		2,643.96	26
27	Replace sidewalks	9/20/2011	6,617.00	661.70	10-0	662		2,481.38	27
28	Repave Parking Lot	11/1/2013	49,636.23	4,963.62	10-0	4,964		8,272.70	28
29	Repave Parking Lot	11/1/2013	54,183.00	5,418.30	10-0	5,418		9,030.50	29
30	Concrete Dumpster Pad	10/8/2014	8,970.00	672.75	10-0	673		672.75	30
31	INSTALL NEW SEWER LINES	7/14/1993	4,104.82	-	10-0			4,104.82	31
32	REPLACE PARTS ON 2 SUMP P	5/24/1994	4,033.53	-	10-0			4,033.53	32
33	Sewage pump	2/7/2009	4,132.90	413.29	10-0	413		2,651.94	33
34	**TOTAL (lines 1 thru 33)**		**$ 3,471,173**	**$ 124,506**		**$ 124,506**	**$**	**$ 2,437,358**	34

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

Facility Name & ID Number Exceptional C & Training Ctr # 0035477 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	$ 270,680	$ 49,392	$ 49,392	$	3-10	$ 160,563	71
72	Current Year Purchases	79,531	8,173	8,173		5-7	8,173	72
73	Fully Depreciated Assets	516,720	11,547	11,547		3-10	516,720	73
74	Depr Exp (Net Allowable) - Rel Pty Alloc Sch VIII		4,280	4,280				74
75	TOTALS	$ 866,931	$ 73,392	$ 73,392	$		$ 685,456	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	2011 Ford E350 Van	2011	$ 41,267	$ 4,127	$ 4,127	$	10	$ 15,819	76
77										77
78										78
79										79
80	TOTALS			$ 41,267	$ 4,127	$ 4,127	$		$ 15,819	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)	$ 4,793,456	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 202,025	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 202,025	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)	$ 3,138,633	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	Vehicle in Excess of 1 Allowed	$ 244,123	$ 31,436	$ 124,498	86
87	Assets below IL Capital Threshold/Other	530,609	32,055	424,664	87
88	Assets Disallowed by HFS Cap Review	533,727	17,851	260,127	88
89					89
90					90
91	TOTALS	$ 1,308,459	$ 81,342	$ 809,289	91

G. Construction-in-Progress

	Description	Cost	
92	Bedroom/bath remodel	$ 60,000	92
93	Matrix Implementation	570	93
94			94
95		$ 60,570	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 C & Training Ctr # 0035477 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - Facility and fixed equipment leased from 100% commonly-owned related party (see SCH VII)

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	Rel Party Home Office Alloc	N/A			8,738	10	10	5
6								6
7	TOTAL				$ 8,738 **			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 ☒ X NO Terms: *

10. Effective dates of current rental agreement:
Beginning 01/01/2011
Ending 01/01/2021

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	6/30/2016	$ Home Office Alloc Amt
13.	6/30/2017	$ Home Office Alloc Amt
14.	6/30/2018	$ Home Office Alloc Amt

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

15. Is Movable equipment rental included in building rental? ☒ X YES ☐ NO

16. Rental Amount for movable equipment: $ 6,308 Description: Copiers/Scanners - Canon Financial Solutions, Inc: $5,059; Postage Meter - Pitney Bowes: $717; Corp Alloc
(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 C & Training Ctr # 0035477 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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

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

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

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

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

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

Aides are either non-certified, hired with certification, or become certified as D.S.P.s rather than CNAs

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Exceptional C & Training Ctr # 0035477 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		72	6,985		72	6,985	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.1	94 hrs	6,751				94	6,751	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.3	# of prescrpts		53	3,463		53	3,463	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	39.3	hrs			8,977			8,977	10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Note: Line 10 practitioner is paid a flat monthly fee and does not report hours.									13
14	TOTAL			$ 6,751	125	$ 19,425	$	219	$ 26,176	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 C & Training Ctr # 0035477 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2015 (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	$ 500	$ 900	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 2,643)	638,648	638,648	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,950	69,145	6
7	Other Prepaid Expenses	9,918	9,918	7
8	Accounts Receivable (owners or related parties)	17,297,122	17,297,122	8
9	Other(specify): Rounding	(3)	(2)	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 17,996,135	$ 18,015,731	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		4,180,597	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		1,507,233	16
17	Accumulated Depreciation (book methods)		(3,947,909)	17
18	Deferred Charges		176,735	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		173,514	21
22	Other Long-Term Assets (spe CIP		60,570	22
23	Other(specify): Goodwill	396,154	396,154	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 396,154	$ 2,960,979	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 18,392,289	$ 20,976,710	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 99,908	$ 99,908	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		160,204	29
30	Accrued Salaries Payable	264,745	264,745	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,000	14,000	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		13,318	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Rel Party Lessor		362,475	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 378,653	$ 914,650	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,131,626	40
41	Bonds Payable			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)**	$	$ 6,131,626	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 378,653	$ 7,046,276	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 18,013,636	$ 13,930,434	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 18,392,289	$ 20,976,710	48

***(See instructions.)**

Facility Name & ID Number Exceptional C & Training Ctr # 0035477 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 17,235,217	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 17,235,217	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	778,419	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)**	$ 778,419	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)**	$ 18,013,636	24	*

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

Facility Name & ID Number Exceptional C & Training Ctr # 0035477 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,281,047	1
2	Discounts and Allowances for all Levels	37	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,281,084	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	108,296	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)**	$ 108,296	23
	D. Non-Operating Revenue		
24	Contributions	22,465	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 22,465	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Developmental Day Training, Misc. Income	1,600,517	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,600,517	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,012,362	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	873,375	31
32	Health Care	2,199,358	32
33	General Administration	1,500,139	33
	B. Capital Expense		
34	Ownership	505,361	34
	C. Ancillary Expense		
35	Special Cost Centers	843,502	35
36	Provider Participation Fee	312,208	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,233,943	40
41	**Income before Income Taxes (line 30 minus line 40)****	778,419	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 778,419	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,281,084	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,281,084	49

* **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 C & Training Ctr # 0035477 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	1,755	1,946	$ 89,463	$ 45.97	1
2	Assistant Director of Nursing	2,064	2,342	69,214	29.55	2
3	Registered Nurses	4,398	4,783	118,601	24.80	3
4	Licensed Practical Nurses	19,453	21,384	476,077	22.26	4
5	CNAs & Orderlies	72,438	78,280	958,765	12.25	5
6	CNA Trainees					6
7	Licensed Therapist	88	94	6,751	71.82	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,823	2,065	44,304	21.45	9
10	Activity Assistants	16,449	18,331	202,857	11.07	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,999	2,145	40,003	18.65	13
14	Head Cook	5,738	6,217	73,681	11.85	14
15	Cook Helpers/Assistants	5,839	6,285	55,069	8.76	15
16	Dishwashers					16
17	Maintenance Workers	1,956	2,149	42,619	19.83	17
18	Housekeepers	10,688	11,777	148,556	12.61	18
19	Laundry	10,840	11,662	149,422	12.81	19
20	Administrator	1,967	2,135	121,152	56.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,227	4,441	67,054	15.10	24
25	Vocational Instruction	47,262	51,266	669,536	13.06	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)	985	1,088	29,995	27.57	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	209,969	228,390	$ 3,363,119 *	$ 14.73	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	95	$ 5,215	1.3	35
36	Medical Director	N/A	21,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant	N/A	15,625	10.3	38
39	Pharmacist Consultant				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)				46
47	*Note: Medical Director paid flat fee, not hourly				47
48					48
49	TOTAL (lines 35 - 48)	95	$ 41,840		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 C & Training Ctr # 0035477 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Melissa Franque	Administrator	0	$ 121,152
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 121,152

B. Administrative - Other

Description	Amount
Group Allocation (See pg 6 for adjustment and Pg 8 for reclass)	$ 113,340
TOTAL (agree to Schedule V, line 17, col. 3)	$ 113,340
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Medical Rehab (dba Ex Living Ctrs)	Management Services	$ 502,800
ADP / Paycor	Payroll Processing	14,087
Various	Accounting/audit services	12,815
Various (see 21.1 for detail)	Legal services	13,593
VCPI, BrekGroup, PhonesPlus	Information Tech Services	1,109
Various	Admin svcs, document svcs	3,430
See Pg 6 for Mgmt Svc Adj		
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 547,835

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 28,674
Unemployment Compensation Insurance	22,898
FICA Taxes	187,020
Employee Health Insurance	253,352
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Retirement Plan	10,655
Group Allocation - Pg 8A	29,467
Less Pg5A Adj for Unallowable DT/EDU	(64,133)
TOTAL (agree to Schedule V, line 22, col.8)	$ 467,933

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	6,852
Health Care Worker Background Check	2,029
(Indicate # of checks performed 100)	
Public Rel/Mkting/Fundraising	17,971
Bank Fees	7,551
Other Dues, Fees, Subs (net)	10,602
Group Allocation - Pg8, 8A	17,483
Less Pg5A Adj for Unallowable DT/EDU	(9,268)
Less other Unallowable Items (5-5A)	(22,418)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,802

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
See Page 21.2 for Detail	458
In-State Travel	
See Page 21.2 for Detail	4,844
Pg 5 Adj - Unallowable Items	(230)
Corporate/Group Travel Alloc - G&A	25,041
Seminar Expense	
Less Unallowable Day Training Alloc	(4,503)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 25,610

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Exceptional C & Training Ctr # 0035477 **Report Period Beginning:** 7/1/2014 **Ending:** 6/30/2015

Exceptional C & Training Ctr
Schedule XIX Supplemental Schedule
Legal Fees Detail

1 Legal Fees detail for SCH XIX-C

DATE	DESCRIPTION	Amount
12/9/2014	Baker, Donelson, Bearman, Caldwell & Berkowi	$ 252.00
12/15/2014	Baker, Donelson, Bearman, Caldwell & Berkowi	$ 1,025.00
2/3/2015	Duane Morris LLP	$ 21.83
4/21/2015	Duane Morris LLP	$ 22.00
5/8/2015	Baker, Donelson, Bearman, Caldwell & Berkowi	$ 189.00
6/16/2015	Duane Morris LLP	$ 22.66
6/16/2015	Stites&Harbison PLLC	$ 139.33
12/15/2014	DeWitt Ross & Stevens	$ 21.26
5/29/2015	Stites&Harbison PLLC	$ 106.00
5/29/2015	Stites&Harbison PLLC	$ 253.33
7/31/2014	In House Counsel Legal Fees	$ 1,036.25
8/31/2014	In House Counsel Legal Fees	$ 1,109.52
9/30/2014	In House Counsel Legal Fees	$ 1,028.24
10/31/2014	In House Counsel Legal Fees	$ 1,099.87
11/30/2014	In House Counsel Legal Fees	$ 1,096.75
12/31/2014	In House Counsel Legal Fees	$ 838.12
1/31/2015	In House Counsel Legal Fees	$ 1,151.34
2/28/2015	In House Counsel Legal Fees	$ 1,037.67
3/31/2015	In House Counsel Legal Fees	$ 1,138.51
4/30/2015	In House Counsel Legal Fees	$ 653.56
5/31/2015	In House Counsel Legal Fees	$ 661.80
6/30/2015	In House Counsel Legal Fees	$ 689.40
		$ 13,593

See Schedule VI for adjustment for unallowable portion.

STATE OF ILLINOIS

Facility Name & ID Number	Exceptional Care & Training Center	#	0035477	Report Period Beginning:	7/1/2014	Ending:

Exceptional Care & Training Center
Schedule XIX Supplemental Schedule
Travel & Seminar In-State detail:

DESCRIPTION	Amount		SCH V LINE.COL
1 In-State Travel Detail			
Linda Burda, staff, care-related in-state travel	113		24.3
Dan Webber, Maint Super, care-related building in-state travel	269		24.3
Sheila Hamilton, Dietary, care-related in-state travel	361		24.3
Wynell Eakle, Bus Office, care-related out of-state travel	42		24.3
Melissa Franque, Exec Director, care-related in-state travel	1,847		24.3
Karla Belzer, Staff, care-related in-state travel	112		24.3
Renae Shrader, Asst DON, care-related in-state travel	71		24.3
Debbie Bieneman, Housekeeping, care-related in-state travel	73		24.3
Barbara Rascoe, Environmental Serv, in-state travel	84	*A*	24.3
Debra K. Buse, Day Training	47	*A*	24.3
Illinois Tollway - Replenish tollway account	100	*A*	24.3
Corporate/Group travel allocation of operations personnel	1,521		24.3
Other non-care related	205		24.3
	4,844		
1 Out-of-State Travel (All to Home Office related training) Detail			
Melissa Franque, Exec Director, care-related out of-state travel	264		24.3
Wynell Eakle, Bus Office, care-related out of-state travel	194		24.3
	458		
Line 24 Column 4 Total:	**5,303**		
Line 24 Column 5 Reclassification - Corporate/Home Office Allocated Costs:	**25,041**		
Unallowable Amounts above removed through SCH 5 Adjustments:			
A Non-care related amounts noted above:	(230)		
Allocation for non-care-related Education and Day Training (See Pg 11.2 & 5A)	(4,503)		
Line 24 Column 8 Total:	**25,610**		

Facility Name & ID Number Exceptional C & Training Ctr # 0035477 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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 C & Training Ctr # 0035477 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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. **ILHCA, $3,092 net after Schedule VI Adj**

(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?

(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. $ **61,203** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **312,208**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
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? **Yes**
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. $ 0

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.