FOR BHF USE

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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 Cr & 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
  - [X] Charitable Corp.
  - [ ] Trust
  - IRS Exemption Code 501(c)(3)
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] 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 07/01/2013 to 06/30/2014 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Kylie Waters
(Title) Sr. VP of Finance

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 Cr & Training Ctr # 0035477 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	29,817	0	0	29,817	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,817			29,817	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.25%

D. How many bed-hold days during this year were paid by the Department?
28 (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 6/30/14 Fiscal Year: FYE 6/30/14

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

Facility Name & ID Number Exceptional Cr & Training Ctr # 0035477 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	173,840	9,073	16,624	199,537		199,537	(28,339)	171,198			1
2	Food Purchase		140,351		140,351		140,351	(19,872)	120,479			2
3	Housekeeping	167,302	13,272		180,574		180,574	(25,568)	155,006			3
4	Laundry	153,729	12,884		166,613		166,613	(23,591)	143,022			4
5	Heat and Other Utilities			81,598	81,598		81,598		81,598			5
6	Maintenance	41,292	12,942	56,610	110,844	8	110,852		110,852			6
7	Other (specify):*											7
8	**TOTAL General Services**	536,163	188,522	154,832	879,517	8	879,525	(97,370)	782,155			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	1,752,976	184,740	17,755	1,955,471	(43,807)	1,911,664	(270,675)	1,640,989			10
10a	Therapy	15,400	71	5,100	20,571		20,571	(2,913)	17,658			10a
11	Activities	238,102	1,806		239,908		239,908	(33,969)	205,939			11
12	Social Services											12
13	CNA Training					43,807	43,807		43,807			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,006,478	186,617	43,855	2,236,950		2,236,950	(307,557)	1,929,393			16
	C. General Administration											
17	Administrative	119,674		87,118	206,792	91,085	297,877	(61,798)	236,079			17
18	Directors Fees											18
19	Professional Services			536,287	536,287	(211,812)	324,475	(307,592)	16,883			19
20	Dues, Fees, Subscriptions & Promotions			39,476	39,476	12,915	52,391	(23,093)	29,298			20
21	Clerical & General Office Expenses	62,740	18,192	37,581	118,513	70,649	189,162	(158,692)	30,470			21
22	Employee Benefits & Payroll Taxes			542,566	542,566	1,165	543,731	(54,513)	489,218			22
23	Inservice Training & Education			7,696	7,696	1,062	8,758	(2,992)	5,766			23
24	Travel and Seminar			9,263	9,263	16,976	26,239	(3,715)	22,524			24
25	Other Admin. Staff Transportation			103	103		103	(103)				25
26	Insurance-Prop.Liab.Malpractice			508	508	3,712	4,220	32,891	37,111			26
27	Other (specify):*			(14,245)	(14,245)		(14,245)	14,245				27
28	**TOTAL General Administration**	182,414	18,192	1,246,353	1,446,959	(14,248)	1,432,711	(565,362)	867,349			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,725,055	393,331	1,445,040	4,563,426	(14,240)	4,549,186	(970,289)	3,578,897			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 Cr & Training Ctr #0035477 **Report Period Beginning:** 07/01/2013 **Ending:** 06/30/2014

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					5,633	5,633	176,529	182,162			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							171,623	171,623			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			548,471	548,471	8,345	556,816	(548,471)	8,345			34
35	Rent-Equipment & Vehicles			5,244	5,244	262	5,506		5,506			35
36	Other (specify):* **Mortgage Ins.**							49,479	49,479			36
37	**TOTAL Ownership**			553,715	553,715	14,240	567,955	(150,840)	417,115			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	631,693	18,249	160,450	810,392		810,392	(781,575)	28,817			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			311,152	311,152		311,152		311,152			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	631,693	18,249	471,602	1,121,544		1,121,544	(781,575)	339,969			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,356,748	411,580	2,470,357	6,238,685		6,238,685	(1,902,704)	4,335,981			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 Care & Training Center	#	0035477	Report Period Beginning:	7/1/2013	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 Allocation)		(67,497)	17.5
	Administration	48,668		17.5
	Professional Services	7,689		19.5
	Dues, Fees, Subscriptions & Promotions	11,133		20.5
	Clerical & General Office Expenses	7		21.5
2	Reclassification of ELC Corporate Expenses			
	Professional Services (Rel. Party Mgmt. Fee)		(227,501)	19.5
	Maintenance	8		6.5
	Administrative	109,914		17.5
	Professional Services	8,000		19.5
	Dues, Fees, Subscriptions & Promotions	1,782		20.5
	Clerical & General Office Expenses	70,642		21.5
	Employee Benefits & Payroll Taxes	1,165		22.5
	Inservice Training & Education	1,062		23.5
	Travel & Seminar	16,976		24.5
	Insurance - Prop.Liab.Malpractice	3,712		26.5
	Depreciation	5,633		30.5
	Interest	-		32.5
	Rent - Facility & Grounds	8,345		34.5
	Rent - Equipment	262		35.5
3	Reclassification of C.N.A. Training Expenses for Trainers/Trainees			
	C.N.A. Training	43,807		13.5
	Nursing & Medical Records		(43,807)	10.5

STATE OF ILLINOIS

Facility Name & ID Number	Exceptional Care & Training Center	#	35477	Report Period Beginning:	41,456	Ending:

Exceptional Care & Training Center
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	All Employees	All Employees	411
	Karen Real CLASS: Food Service Sanitation Manager Certification	Barbara Hasselbacher-Sarber	Cook	60
	Illinois Council on Long Term Care Publications: Standardized Admissing Packet/ Nursing Quality Assurance Program for LTC Facilities	All Employees	All Employees	200
	Channing Bete Company, Inc. CPR AED Trainer	All Employees	All Employees	80
	API WorkSafe CLASS: Operator Training & Examination Program	Daniel Webber	Maintenance Director	160
	State of Illinois Department of Public Health CLASS: Food Service Sanitation Manager Certification	Rachel Dugger	Cook	120
A	Rudolph Muzzarelli CLASS: IHFS Certificate (Driver Safety Training)	Transport Ees	Transportation	1,200
	MDI Achieve Directions 2013 Seminar	Melissa Francque Gwnen Justice	Executive Director Director of Nursing	95 95
	Silverchair Learning Systems Core Curriculum Education Software Quarterly Bill - billing for October - December	All Employees	All Employees	411
A	AMDA AMDA Conference	John Noffsinger	Director of Marketing	35
	Illinois Health Care Association	Melissa Francque	Executive Director	13

A	CLASS: Legal Implications of Technology Use in LTC Facilities	Karla Belzer	Day Training - Program Director	13
A		Dianne McFadden	Day Training - QMRP	13
		Renae Shrader	Asst Director of Nursing	13
A		Amanda Zook	Day Training - QMRP	13
A		Patricia Fazekas	Day Training - QMRP	13
A	Illinois Health Care Association	Amanda Zook	Day Training - QMRP	75
	CLASS: Legal Implications of Technology Use in LTC Facilities, Log on & CEUs	Renae Shrader	Asst Director of Nursing	15
A		Patti Fazekas	Day Training - QMRP	15
A		Karla Belzer	Day Training - Program Director	15
A	Sauk Valley Area Chamber of Commerce Professional Women's Network Quarterly Event - February (11 Participants)			132
	Silverchair Learning Systems Core Curriculum Education Software Quarterly Bill - billing for January - March	All Employees	All Employees	1,598
	AANAC CLASS: Resident Assessment Coding Certification	Yvonne Vandosdol	Regional Director of Clinical Services	10
A	YWCA of the Sauk Valley Women of Achievement Luncheon (5 reservations)			150
A	NCTRC Annual CTRS recertification			80
	Silverchair Learning Systems Core Curriculum Education Software Quarterly Bill - billing for April - June	All Employees	All Employees	1,598
	CPR Savers Prestan Single Adult Manikin	All Employees	All Employees	280
	Silverchair Learning Systems Core Curriculum Education Software Quarterly Bill - billing for May - June	All Employees	All Employees	788
	Line 23 Column 4 Total:			**7,696**

	Line 23 Column 5 Reclassification - Corporate/Home Office Allocated Costs:	1,062
	Line 23 Column 6 Total:	**8,758**
	Unallowable Amounts above removed through SCH 5 Adjustments:	
A	Non-care related amounts noted above:	(1,752)
	Allocation for non-care-related Education and Day Training (See Pg 11.2 & 5A)	(1,240)
	Line 23 Column 8 Total:	**5,766**

Facility Name & ID Number Exceptional Cr & Training Ctr # 0035477 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	(781,575)	39		3
4	Non-Patient Meals	(86)	1		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	(147)	32		10
11	Discounts, Allowances, Rebates & Refunds	(14,606)	21		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)	(103)	25		16
17	Non-Care Related Fees	(1,752)	23		17
18	Fines and Penalties	(5,775)	20		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(750)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	14,245	27		24
25	Fund Raising, Advertising and Promotional	(19,973)	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 See PG 5A	(771,118)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,581,640)		$	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)	(321,064)	17, 19	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (321,064)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,902,704)		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					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Exceptional Cr & Training Ctr

ID# 0035477

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Contributions Received - Income Offset	$ (117,302)	21	1
2	Unallowable Depr Exp (below threshold, non-cap)	(64,740)	30	2
3	Unallowable Lobbying Portion of ILHCA Dues	(1,847)	20	3
4	Unallowable Day Trng Alloc - Dietary	(28,253)	1	4
5	Unallowable Day Trng Alloc - Food	(19,872)	2	5
6	Unallowable Day Trng Alloc - Hskpg	(25,568)	3	6
7	Unallowable Day Trng Alloc - Laundry	(23,591)	4	7
8	Unallowable Day Trng Alloc - Nursing	(270,675)	10	8
9	Unallowable Day Trng Alloc - Therapy	(2,913)	10a	9
10	Unallowable Day Trng Alloc - Activities	(33,969)	11	10
11	Unallowable Day Trng Admin Alloc	(42,177)	17	11
12	Unallowable Day Trng Prof Svcs Alloc	(45,943)	19	12
13	Unallowable Day Trng Dues/Fees Alloc	(7,418)	20	13
14	Unallowable Day Trng Clerical Alloc	(26,784)	21	14
15	Unallowable Day Trng EE Ben Alloc	(54,513)	22	15
16	Unallowable Day Trng Insrv/Trn Alloc	(1,240)	23	16
17	Unallowable Day Trng Travel/Seminar Alloc	(3,715)	24	17
18	Unallowable Day Trng Insur Alloc	(598)	26	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**	(771,118)		49

Facility Name & ID Number Exceptional Cr & Training Ctr # 0035477 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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%	Swann Special Care Center	Champaign, IL	Medical Rehabilitation	Lexington, KY	Mgmt Co.
		Walter Lawson Children's Home	Loves Park, 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	Group Cost Center	$ 87,118	Hoosier Care, Inc.	100.00%	$ 67,497	$ (19,621)	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	488,400	Medical Rehabilitation Centers, LLC	37.50%	227,501	(260,899)	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 ADJUSTMENTS CONTINUED ON THE NEXT PAGE (6A)					(40,544)	11
12	V								12
13	V								13
14	Total			$ 575,518			$ 294,998	$ * (321,064)	14

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

Facility Name & ID Number Exceptional Cr & Training Ctr # 0035477 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	$ 548,471	Sterling Facility Company, LLC	100.00%	$	$ (548,471)	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		241,269	241,269	21
22	V	32	Actual Interest of Rel Pty		-Interest (net of interest income)		165,309	165,309	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		33,489	33,489	24
25	V	36	Actual Mortgage Ins of Rel Pty		-Mortgage Insurance		49,479	49,479	25
26	V	20	Actual Bank & Audit Fees of Rel Pty		-Bank & Audit Fees		11,920	11,920	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 548,471			$ 507,927	$ * (40,544)	39

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

Facility Name & ID Number Exceptional Cr & Training Ctr # 0035477 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	48,668	17.8	12
13								TOTAL	$ 48,668		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.**

Amounts paid for Home Office Administration Fees by other Nursing Homes

Walter Lawson Children's Home	66,344	Illinois
Swann Special Care Center	79,617	Illinois
Exceptional Care & Training Center	48,668	Illinois
Vernon Manor Children's Home	45,363	Indiana
Exceptional Living Center of Brazil	56,710	Indiana
Richland-Bean Blossom Health Care	48,168	Indiana
Randolph Nursing Home	41,545	Indiana

Net allowable Related Party Management Fees paid by other Nursing Homes

Walter Lawson Children's Home	310,130	Illinois
Swann Special Care Center	372,177	Illinois
Exceptional Care & Training Center	227,501	Illinois
Vernon Manor Children's Home	212,053	Indiana
Exceptional Living Center of Brazil	265,096	Indiana
Richland-Bean Blossom Health Care	225,165	Indiana
Randolph Nursing Home	194,205	Indiana

Facility Name & ID Number Exceptional Cr & Training Ctr # 0035477 Report Period Beginning: 07/01/2013 Ending: 6/30/2014

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	40,915,656	7	$ 386,413	$ 0	5,153,213	$ 48,668	1
2	19	Professional Services	Direct Cost	40,915,656	7	61,051	0	5,153,213	7,689	2
3	20	Dues, Fees, Subscriptions & Prom	Direct Cost	40,915,656	7	88,392	0	5,153,213	11,133	3
4	21	Clerical & General Office Expens	Direct Cost	40,915,656	7	53	0	5,153,213	7	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					$ 535,909	$		$ 67,497	25

Facility Name & ID Number Exceptional Care & Training Center # 35477 Report Period Beginning: 7/1/2013 Ending: 06/30/2014

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, db
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	81,571,805	15	$ 120	$	5,153,213	$ 8
2	17	Administrative	Direct Costs	81,571,805	15	1,739,864	1,739,864	5,153,213	109,914
3	19	Professional Services	Direct Costs	81,571,805	15	126,640		5,153,213	8,000
4	20	Dues, Fees, Subscriptions	Direct Costs	81,571,805	15	28,212		5,153,213	1,782
5	21	Clerical & General Office	Direct Costs	81,571,805	15	1,118,216	944,495	5,153,213	70,642
6	22	Employee Benefits & Payroll Tax	Direct Costs	81,571,805	15	18,436		5,153,213	1,165
7	23	Inservice Training & Education	Direct Costs	81,571,805	15	16,818		5,153,213	1,062
8	24	Travel & Seminar	Direct Costs	81,571,805	15	268,725		5,153,213	16,976
9	26	Insurance	Direct Costs	81,571,805	15	58,760		5,153,213	3,712
10	30	Depreciation	Direct Costs	81,571,805	15	89,168		5,153,213	5,633
11	32	Interest	Direct Costs	81,571,805	15	0		5,153,213	0
12	34	Rent - Facility & Grounds	Direct Costs	81,571,805	15	132,093		5,153,213	8,345
13	35	Rent - Equipment	Direct Costs	81,571,805	15	4,150		5,153,213	262
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25	TOTALS					$ 3,601,202	$ 2,684,359		$ 227,501

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Facility Name & ID Number Exceptional Cr & Training Ctr # 0035477 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	LP Mortgage HUD Loan		X	Facility Purchase	$26,513.35	11/1/12	$ 6,675,000	$ 6,448,020	11/1/42	0.0254	$ 165,561	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												7
8												8
9	TOTAL Facility Related				$26,513.35		$ 11,675,000	$ 6,448,020			$ 165,561	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 11,675,000	$ 6,448,020			$ 165,561	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 49,479** **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 Cr & Training Ctr # 0035477 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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 2014 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:			
	2009		8
	2010		9
	2011		10
	2012		11
	2013		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 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Exceptional Cr & 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 2013 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 2013.

	(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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 Cr & Training Ctr # 0035477 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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

Facility Name & ID Number	Exceptional Cr & Training Ctr	# 0035477	Report Period Beginning: 7/1/2013	Ending: 6/30/2014

Exceptional Cr & 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.

	SNF	DT
% of Salaries for alloc of EE Benefits/PR Taxes	85%	15%
% of total program hours operated for other items	86%	14%

Facility Name & ID Number Exceptional Cr & Training Ctr # 0035477 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	$	$ 1,749,166	4
5	15			1991	358,311	11,944	30	11,944		275,263	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		3,371.46	23
24	NEW TILE IN DINING RM/CLA			4/11/2000	4,770.00	318.00	15-0	318		4,531.50	24
25	FURNISH & INSTALL AWNING.			4/6/2001	2,771.26	184.75	15-0	185		2,448.05	25
26	LABOR & MAT-BREAKER PANEL			4/12/2001	3,930.00	262.00	15-0	262		3,471.41	26
27	INSTALL WATER HEATER			7/5/2001	3,341.20	222.75	15-0	223		2,895.69	27
28	INTERNET SET-UP-WIRING CA			2/21/2002	3,060.62	204.04	15-0	204		2,533.44	28
29	STORM WINDOW PROJECT			6/24/2002	8,937.00	446.85	20-0	447		5,399.47	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		6,803.42	32
33	New roof			3/2/2006	15,986.69	1,598.67	10-0	1,599		13,322.25	33
34	Water heater			6/16/2006	4,716.60	471.66	10-0	472		3,773.28	34
35	Sprinkler system-Phase I			6/30/2006	33,165.00	2,211.00	15-0	2,211		17,688.00	35
36	Sprinkler system-Phase II			6/30/2006	7,920.00	528.00	15-0	528		4,224.00	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 Cr & Training Ctr # 0035477 **Report Period Beginning:** 07/01/2013 **Ending:** 06/30/2014

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	Sprinkler system-Phase III	9/21/2006	$ 13,365.00	$ 891.00	15-0	$ 891	$	$ 6,905.25	37
38	Light fixtures (24) and new wiring	1/22/2007	6,433.74	428.92	15-0	429		3,181.16	38
39	Ductwork & roof exhaust for new dryer	3/15/2007	3,497.88	233.19	15-0	233		1,710.06	39
40	Brake assembly on dumbwaiter	7/24/2007	4,389.00	292.60	15-0	293		2,023.82	40
41	Tile walls in classrooms 1-4, 8	1/22/2008	9,300.00	620.00	15-0	620		3,978.33	41
42	Privacy wall in day rooms (2)	6/6/2008	3,297.37	219.82	15-0	220		1,337.24	42
43	Wiring & outlets for kitchen & dayrooms	9/26/2008	3,434.00	228.93	15-0	229		1,316.35	43
44	Exit & boiler room doors replaced	12/18/2008	2,711.50	180.77	15-0	181		994.23	44
45	Avaya phone system for day training	5/21/2009	7,010.00	701.00	10-0	701		3,563.42	45
46	5 ton rooftop hvac unit	7/9/2009	6,485.00	432.33	15-0	432		2,161.65	46
47	26 x 12 storage shed	7/12/2009	8,280.00	552.00	15-0	552		2,760.00	47
48	Water heaters (2)	8/13/2009	11,250.00	1,125.00	10-0	1,125		5,531.25	48
49	Grease trap replaced and electric & tile	5/20/2010	7,217.12	481.14	15-0	481		1,964.66	49
50	Roof for courtyard pavillion	5/28/2010	6,657.00	443.80	15-0	444		1,812.18	50
51	Tile work for walls in south & east hall	7/15/2010	11,593.55	1,159.36	10-0	1,159		4,637.44	51
52	Misc electrical work	10/6/2010	4,915.00	327.67	15-0	328		1,228.76	52
53	Main drain line replaced	10/9/2010	2,818.05	187.87	15-0	188		704.51	53
54	Parapet wall on roof	10/28/2010	8,215.00	410.75	20-0	411		1,506.08	54
55	Remodel restroom for isolation room	2/28/2011	2,556.18	255.62	10-0	256		852.07	55
56	Tile in lobby and surrounding areas	6/14/2011	3,274.25	327.43	10-0	327		1,009.58	56
57	Roof hvac units (2)	10/3/2011	8,173.00	817.30	10-0	817		2,247.58	57
58	Water heater for south wing	10/4/2011	7,936.94	793.69	10-0	794		2,182.65	58
59	Replace header on basement door	12/7/2011	4,870.21	324.68	15-0	325		838.76	59
60	Medical room remodel	12/1/2012	8,081.62	808.16	10-0	808		1,279.59	60
61	Boiler	3/1/2013	22,524.83	1,501.66	15-0	1,502		2,002.21	61
62	Bryant a/c units (2) and dishwasher hood	4/12/2013	13,875.00	925.00	15-0	925		1,156.25	62
63	Boiler Repair/Replacement	7/23/2013	29,683.28	2,720.97	10-0	2,721		2,720.97	63
64	Nurses Station Remodel	8/15/2013	19,747.00	1,810.14	10-0	1,810		1,810.14	64
65	Nurses Station Remodel	10/2/2013	19,748.00	1,481.10	10-0	1,481		1,481.10	65
66	Replaced Fire Door	10/3/2013	5,615.00	421.13	10-0	421		421.13	66
67	New Dumbwaiter	12/20/2013	10,898.00	544.90	10-0	545		544.90	67
68	Installation of dumbwaiter	4/10/2014	21,797.00	544.93	10-0	545		544.93	68
69	New Tile	6/12/2014	2,578.41	21.49	10-0	21		21.49	69
70	**TOTAL (lines 4 thru 69)**		**$ 3,183,251**	**$ 99,602**		**$ 99,602**	**$**	**$ 2,245,340**	70

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

Facility Name & ID Number Exceptional Cr & Training Ctr # 0035477 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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		$ 3,183,251	$ 99,602		$ 99,602	$	$ 2,245,340	1
2	GATE & FENCE SCARS	5/29/1992	4,038.00	-	10-0			4,038.00	2
3	NEW WATER MAIN	10/11/1993	12,203.63	-	10-0			12,203.63	3
4	RESEAL PARKING AREA	6/7/1997	2,845.00	-	10-0			2,845.00	4
5	TANK REPLACEMENT - PIPECO	9/28/1998	9,890.00	494.50	20-0	495		7,829.68	5
6	EXCAVATION OF NEW PARKING	5/11/2001	12,415.00	620.75	20-0	621		8,173.23	6
7	WALKWAY	8/28/2001	4,119.05	274.60	15-0	275		3,546.84	7
8	PRIVACY FENCE	6/20/2002	2,550.00	-	10-0			2,550.00	8
9	Parking Lot Renovation	9/11/2004	3,499.00	349.90	10-0	350		3,403.18	9
10	Portions of parking lot replaced/resurfa	10/20/2008	3,670.00	367.00	10-0	367		2,079.67	10
11	Concrete sidewalk for emergency exit	7/26/2009	7,119.00	474.60	15-0	475		2,333.45	11
12	Trex security fence	9/28/2009	9,142.00	609.47	15-0	609		2,894.98	12
13	Greenhouse for therapy use	12/22/2010	12,474.83	1,247.48	10-0	1,247		4,366.18	13
14	Rentention pond	6/6/2011	7,273.10	727.31	10-0	727		2,242.54	14
15	Hardscape & landscape for rentention pon	6/6/2011	3,936.00	393.60	10-0	394		1,213.60	15
16	Vinyl coated chain link fence	6/7/2011	6,475.00	647.50	10-0	648		1,996.46	16
17	Replace sidewalks	9/20/2011	6,617.00	661.70	10-0	662		1,819.68	17
18	Repave Parking Lot	11/1/2013	49,636.23	3,309.08	10-0	3,309		3,309.08	18
19	Repave Parking Lot	11/1/2013	54,183.00	3,612.20	10-0	3,612		3,612.20	19
20	INSTALL NEW SEWER LINES	7/14/1993	4,104.82	-	10-0			4,104.82	20
21	REPLACE PARTS ON 2 SUMP P	5/24/1994	4,033.53	-	10-0			4,033.53	21
22	Sewage pump	2/7/2009	4,132.90	413.29	10-0	413		2,238.65	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)**		$ 3,407,608	$ 113,805		$ 113,805	$	$ 2,326,174	34

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

Facility Name & ID Number Exceptional Cr & Training Ctr # 0035477 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	$ 325,724	$ 55,526	$ 55,526	$	3-10	$ 172,115	71
72	Current Year Purchases	14,073	247	247		3-7	247	72
73	Fully Depreciated Assets	443,855	2,824	2,824		3-15	443,855	73
74	Depr Exp - Rel Pty Alloc Sch VIII		5,633	5,633				74
75	TOTALS	$ 783,652	$ 64,230	$ 64,230	$		$ 616,217	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	$ 11,692	76
77										77
78										78
79										79
80	TOTALS			$ 41,267	$ 4,127	$ 4,127	$		$ 11,692	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)	$ 4,646,612	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 182,162	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 182,162	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,954,083	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	$ 14,603	$ 93,062	86
87	Assets below IL Capital Threshold	496,471	32,342	393,655	87
88	Assets Disallowed by HFS Cap Review	533,727	17,795	242,276	88
89					89
90					90
91	TOTALS	$ 1,274,321	$ 64,740	$ 728,993	91

G. Construction-in-Progress

	Description	Cost	
92	Emergency Generator	$ 21,550	92
93			93
94			94
95		$ 21,550	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 Cr & Training Ctr # 0035477 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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			8,345	10	10	5
6								6
7	TOTAL				$ 8,345 **			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.	06/30/2015	$ Home Office Alloc Amt
13.	06/30/2016	$ Home Office Alloc Amt
14.	06/30/2016	$ 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: $ 5,506 Description: Copiers/Scanners - Canon Financial Solutions, Inc: $4,875; Postage Meter - Pitney Bowes: $368; 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 Cr & Training Ctr # 0035477 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	50

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER CNA	90

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)		13,182		13,182
4	Clinical Wages (b)		29,660		29,660
5	In-House Trainer Wages (c)		964		964
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 43,807	$	$ 43,807
10	SUM OF line 9, col. 1 and 2 (e)	$ 43,807			

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	28
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	28

(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 Cr & Training Ctr # 0035477 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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		60	5,100		60	5,100	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.1	220 hrs	15,400				220	15,400	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	3,479		53	3,479	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	39.3	hrs			7,264			7,264	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			$ 15,400	113	$ 15,843	$	333	$ 31,243	14

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

STATE OF ILLINOIS

Facility Name & ID Number Exceptional Cr & Training Ctr # 0035477 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2014 (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	$ 18,545	1
2	Cash-Patient Deposits	49,809	49,809	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,012,084	1,012,084	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	89,485	113,768	6
7	Other Prepaid Expenses	9,524	9,524	7
8	Accounts Receivable (owners or related parties)	16,203,483	16,135,291	8
9	Other(specify): Rounding			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 17,364,885	$ 17,339,021	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		414,085	13
14	Buildings, at Historical Cost		3,945,602	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		1,582,795	16
17	Accumulated Depreciation (book methods)		(3,683,076)	17
18	Deferred Charges		429,067	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Goodwill	396,154	396,154	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 396,154	$ 3,084,627	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 17,761,039	$ 20,423,648	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 136,952	$ 141,687	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	49,809	49,809	28
29	Short-Term Notes Payable		156,190	29
30	Accrued Salaries Payable	258,869	258,869	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,000	12,000	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		13,648	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Rel Party Lessor	68,192	331,879	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 525,822	$ 964,082	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,291,830	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)**	$	$ 6,291,830	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 525,822	$ 7,255,912	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 17,235,217	$ 13,167,736	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 17,761,039	$ 20,423,648	48

*(See instructions.)

Facility Name & ID Number Exceptional Cr & Training Ctr **#** 0035477 **Report Period Beginning:** 07/01/2013 **Ending:** 06/30/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 16,515,689	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 16,515,689	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	719,528	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)**	$ 719,528	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)**	$ 17,235,217	24	*

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

Facility Name & ID Number Exceptional Cr & Training Ctr # 0035477 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	$ 5,189,346	1
2	Discounts and Allowances for all Levels	(287)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,189,059	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	52,919	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	86	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	174	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 53,179	23
	D. Non-Operating Revenue		
24	Contributions	117,302	24
25	Interest and Other Investment Income***	147	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 117,449	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Developmental Day Training, Misc. Income	1,598,526	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,598,526	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,958,213	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	879,517	31
32	Health Care	2,236,950	32
33	General Administration	1,446,959	33
	B. Capital Expense		
34	Ownership	553,715	34
	C. Ancillary Expense		
35	Special Cost Centers	810,392	35
36	Provider Participation Fee	311,152	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,238,685	40
41	**Income before Income Taxes (line 30 minus line 40)****	719,528	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 719,528	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,189,059	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)	$ 5,189,059	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 Cr & Training Ctr # 0035477 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	1,900	2,100	$ 71,779	$ 34.18	1
2	Assistant Director of Nursing	1,930	2,171	68,063	31.35	2
3	Registered Nurses	4,264	4,588	119,847	26.12	3
4	Licensed Practical Nurses	19,347	21,240	467,818	22.03	4
5	CNAs & Orderlies	75,973	82,488	986,483	11.96	5
6	CNA Trainees					6
7	Licensed Therapist	204	220	15,400	70.00	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,921	2,162	46,398	21.46	9
10	Activity Assistants	15,253	16,830	191,704	11.39	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,026	2,151	39,581	18.40	13
14	Head Cook	5,679	6,256	77,990	12.47	14
15	Cook Helpers/Assistants	6,101	6,473	56,269	8.69	15
16	Dishwashers					16
17	Maintenance Workers	1,941	2,122	41,292	19.46	17
18	Housekeepers	11,768	12,973	167,302	12.90	18
19	Laundry	11,294	12,177	153,729	12.62	19
20	Administrator	2,035	2,165	119,674	55.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,545	3,856	62,740	16.27	24
25	Vocational Instruction	38,055	41,283	513,727	12.44	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	6,421	7,027	117,966	16.79	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,543	1,696	38,986	22.99	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	211,200	229,978	$ 3,356,748 *	$ 14.60	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	381	$ 14,803	1, 3	35
36	Medical Director	N/A	21,000	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant	624	17,617	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					47
48					48
49	TOTAL (lines 35 - 48)	1,005	$ 53,420		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 Cr & Training Ctr # 0035477 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Melissa Franque	Administrator	0%	$ 119,674
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 119,674

B. Administrative - Other

Description	Amount
Corporate/Group Admin Allocation	$ 87,118
TOTAL (agree to Schedule V, line 17, col. 3)	$ 87,118
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Medical Rehabilitation Centers, LLC	Management Services	$ 488,400
Automated Data Processing	Payroll Services	15,822
Various - SEE PG 21.2 for detail	Legal Fees	19,349
Various - Accting/Audit Fees	Accting Fees/Audit	10,315
Contract Svcs - Other	IT and Other Admin Svcs	2,401
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 536,287

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 37,537
Unemployment Compensation Insurance	125,612
FICA Taxes	100,468
Employee Health Insurance	268,869
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Employee Benefits - Retirement Plan Contrib	10,080
Corporate/Group Allocation	1,165
Less Unallowable Day Training Alloc	(54,513)
TOTAL (agree to Schedule V, line 22, col.8)	$ 489,218

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	4,003
Health Care Worker Background Check	2,102
(Indicate # of checks performed 137)	
Public Relations/Mkting/FundRaising	19,973
IL Healthcare Association	4,692
Other Dues, Fees, Subscriptions	8,706
Corporate/Group Allocation	24,835
Less: Unallowable Fees & Penalties & Exp	(15,040)
Less: Public Relations Expense	(19,973)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,298

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
See Page 21.1 for Detail	2,379
In-State Travel	
See Page 21.1 for Detail	2,265
Corporate/Group Travel Alloc - G&A	21,595
Seminar Expense	
Less Unallowable Day Training Alloc	(3,715)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 22,524

* Attach copy of IMRF notifications

**See instructions.

STATE OF ILLINOIS

Facility Name & ID Number	Exceptional Care & Training Center	#	0035477	Report Period Beginning:	7/1/2013	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		
Melissa Franque, Exec Director, care-related in-state travel	135	24.3
Karla Belzer, Staff, care-related in-state travel	86	24.3
Wynell Eakle, Bus Office, care-related in-state travel	58	24.3
Melissa Franque, Exec Director, care-related in-state travel	79	24.3
Melissa Franque, Exec Director, care-related in-state travel	152	24.3
Karla Belzer, Staff, care-related in-state travel	75	24.3
Melissa Franque, Exec Director, care-related in-state travel	156	24.3
Melissa Franque, Exec Director, care-related in-state travel	137	24.3
Melissa Franque, Exec Director, care-related in-state travel	137	24.3
Melissa Franque, Exec Director, care-related in-state travel	137	24.3
Dan Webber, Maint Super, care-related building in-state trav	129	24.3
Gwen Justice, Dir of Nursing,care-related in-state travel	93	24.3
Dan Webber, Maint Super, care-related building in-state trav	67	24.3
Melissa Franque, Exec Director, care-related in-state travel	46	24.3
Melissa Franque, Exec Director, care-related in-state travel	172	24.3
Karla Belzer, Staff, care-related in-state travel	65	24.3
Debbie Bieneman, Houskeeping, care-related in-state travel	67	24.3
Stephanie Bieneman, Staff, care-related in-state travel	167	24.3
Melissa Franque, Exec Director, care-related in-state travel	305	24.3
	2,265	
1 Out-of-State Travel (All to Home Office related training) Detail		
Wynell Eakle, Bus Office, care-related out of-state travel	728	24.3
Melissa Franque, Exec Director, care-related out of-state trav	183	24.3
Wynell Eakle, Bus Office, care-related out of-state travel	1,468	24.3
	2,379	

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

1 Legal Fees detail for SCH XIX-C

DATE	DESCRIPTION	Amount
8/9/2013	Michigan Peer Review Organization Admin	$ 4,800
9/23/2013	Duane Morris LLP	$ 42
10/8/2013	Bradley Arant Boult Cummings LLP	$ 259
10/14/2013	Cash - Legal	$ 70
10/15/2013	Duane Morris LLP	$ 21
11/5/2013	Bradley Arant Boult Cummings LLP	$ 437
11/30/2013	Bradley Arant Boult Cummings LLP	$ 1,726
12/31/2013	jb-rcl ap 53141 GE portion	$ (129)
12/31/2013	jb-rcls ap 58824 GE portion	$ (1,287)
1/30/2014	Duane Morris LLP	$ 21
3/17/2014	Marvin G. Ripley, Attorney at Law	$ 710
4/28/2014	Baker, Donelson, Bearman, Caldwell & Berkowitz, PC	$ 299
6/30/2014	6.14 Accrued Expenses #2	$ 731
6/30/2014	6.14 Accrued Expenses #2	$ 163
7/28/2013	In House Counsel Legal Fees	$ 1,050
8/28/2013	In House Counsel Legal Fees	$ 544
9/30/2013	In House Counsel Legal Fees	$ 1,003
10/31/2013	In House Counsel Legal Fees	$ 912
11/30/2013	In House Counsel Legal Fees	$ 948
12/31/2013	In House Counsel Legal Fees	$ 1,327
12/31/2013	In House Counsel Legal Fees	$ (73)
1/31/2014	In House Counsel Legal Fees	$ 1,035
2/28/2014	In House Counsel Legal Fees	$ 786
3/31/2013	In House Counsel Legal Fees	$ 1,039
4/30/2014	In House Counsel Legal Fees	$ 990
5/31/2014	In House Counsel Legal Fees	$ 913
6/30/2014	In House Counsel Legal Fees	$ 506
6/30/2014	In House Counsel Legal Fees	$ 430
8/16/2013	Bradley Arant Boult Cummings LLP	$ 20

12/17/2013	DeWitt Ross & Stevens	$	37
12/27/2013	Taft Stettinius & Hollister LLP	$	19
		$	**19,349**

Facility Name & ID Number Exceptional Cr & Training Ctr # 0035477 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	Not Applicable		$		$	$	$	$	$	$	$	$	$
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 Cr & Training Ctr # 0035477 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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, $2,845 net after SCH VI adjustment**

(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. $ **60,169** 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 **No** 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. $ **311,152**
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. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **86**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes, Corp Home Office**
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.