

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: 0035477

Facility Name: Exceptional Care & Training Center

Address: 2601 Woodlawn Road Sterling 61081
Number City 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:

☒ VOLUNTARY,NON-PROFIT
☒ 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) 317-4040
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2011 to 06/30/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Kylie Waters Whipple
(Title) Vice President of Finance - Exceptional Living Centers

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 Care & Training Center# 0035477 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2	84	Skilled Pediatric (SNF/PED)	84	30,744	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	30,744	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED		115	30,183	30,298	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS		115	30,183	30,298	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 98.55%

D. How many bed-hold days during this year were paid by the Department?

178 (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?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒NO ☐

I. On what date did you start providing long term care at this location?

Date started 08/15/1989

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 08/15/1989NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐NO ☒If YES, enter number
of beds certified _____ and days of care provided _____Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 06/30/2012 Fiscal Year: 06/30/2012

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

III. STATISTICAL DATA

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

☒

NO

☐

Note: Unamortized Bond Acquisition Costs not related to patient care of \$61,379 have been included on line 18 of the Balance Sheet.

Starting: 07/01/2011 Ending: 06/30/2012

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	172,706	12,359	27,001	212,066		212,066		212,066		1
2	Food Purchase		141,472		141,472		141,472		141,472		2
3	Housekeeping	165,480	15,229		180,709	(19)	180,690		180,690		3
4	Laundry	150,298	7,961	886	159,145		159,145		159,145		4
5	Heat and Other Utilities			84,857	84,857	617	85,474	(95)	85,379		5
6	Maintenance	49,223	21,724	58,444	129,391	778	130,169		130,169		6
7	Other (specify):*										7
8	TOTAL General Services	537,707	198,745	171,188	907,640	1,376	909,016	(95)	908,921		8
	B. Health Care and Programs										
9	Medical Director			21,000	21,000		21,000		21,000		9
10	Nursing and Medical Records	1,776,241	141,146	22,668	1,940,055	(71,309)	1,868,746		1,868,746		10
10a	Therapy	11,742	205	8,489	20,436		20,436		20,436		10a
11	Activities	250,053	2,293	43	252,389	(20)	252,369		252,369		11
12	Social Services										12
13	CNA Training					72,217	72,217		72,217		13
14	Program Transportation		301	21,272	21,573		21,573		21,573		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,038,036	143,945	73,472	2,255,453	888	2,256,341		2,256,341		16
	C. General Administration										
17	Administrative	119,713		175,934	295,647	(112,149)	183,498	(17,433)	166,065		17
18	Directors Fees										18
19	Professional Services			535,141	535,141	(223,437)	311,704	(215,229)	96,475		19
20	Dues, Fees, Subscriptions & Promotions			40,181	40,181	41,324	81,505	(29,486)	52,019		20
21	Clerical & General Office Expenses	100,626	26,555	38,622	165,803	232,966	398,769	(22,455)	376,314		21
22	Employee Benefits & Payroll Taxes			540,411	540,411	9,104	549,515		549,515		22
23	Inservice Training & Education			8,457	8,457	1,037	9,494		9,494		23
24	Travel and Seminar			7,282	7,282	12,669	19,951	(560)	19,391		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			42,175	42,175	5,520	47,695		47,695		26
27	Other (specify):* Indigent Care			3,589	3,589		3,589	(3,589)			27
28	TOTAL General Administration	220,339	26,555	1,391,792	1,638,686	(32,966)	1,605,720	(288,752)	1,316,968		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,796,082	369,245	1,636,452	4,801,779	(30,702)	4,771,077	(288,847)	4,482,230		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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			201,145	201,145	6,211	207,356	(13,716)	193,640			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			380,610	380,610	12,006	392,616	(86,120)	306,496			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds					12,509	12,509		12,509			34
35	Rent-Equipment & Vehicles			4,764	4,764	331	5,095		5,095			35
36	Other (specify):* Amortization			11,211	11,211	514	11,725	(2,074)	9,651			36
37	TOTAL Ownership			597,730	597,730	31,571	629,301	(101,910)	527,391			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			17,861	17,861		17,861		17,861			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			311,062	311,062		311,062		311,062			42
43	Other (specify):* Day Training	687,520	2,876	144,460	834,856	(869)	833,987		833,987			43
44	TOTAL Special Cost Centers	687,520	2,876	473,383	1,163,779	(869)	1,162,910		1,162,910			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,483,602	372,121	2,707,565	6,563,288		6,563,288	(390,757)	6,172,531			45

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

Exceptional Care & Training Center

Schedule V Supplemental Schedule

"Other" Amounts in excess of \$1,000

Lines 36 and 43

Section D	Col. 3
Other Expense (Line 36)	Other
Amortization of Bond Issu	11,211
TOTAL	11,211

Section E	Col. 1	Col. 2	Col. 3
Other Expense (Line 43)	Salary/Wage	Supplies	Other
Day Training	738,714	2,833	93,308
TOTAL	738,714	2,833	93,308

07/01/2011

Ending: 06/30/2012

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)		(175,934)	17.5
Heat & Other Utilities	617		5.5
Maintenance	566		6.5
Administration	46,352		17.5
Professional Services	44,317		19.5
Dues, Fees, Subscriptions & Promotions	32,336		20.5
Clerical & General Office Expenses	11,417		21.5
Employee Benefits & Payroll Taxes	6,813		22.5
Travel & Seminar	2,327		24.5
Insurance - Prop.Liab.Malpractice	(37)		26.5
Depreciation	230		30.5
Interest	12,006		32.5
Rent - Facility & Grounds	959		34.5
Rent - Equipment	84		35.5
Other (Amort)	514		36.5
2 Reclassification of ELC Corporate Expenses			
Professional Services (Rel. Party Mgmt. Fee)		(460,800)	19.5
Maintenance	212		6.5
Professional Services	6,442		19.5
Dues, Fees, Subscriptions & Promotions	8,988		20.5
Clerical & General Office Expenses	221,549		21.5
Employee Benefits & Payroll Taxes	2,291		22.5
Inservice Training & Education	1,037		23.5
Travel & Seminar	10,342		24.5
Insurance - Prop.Liab.Malpractice	5,557		26.5
Depreciation	5,981		30.5
Rent - Facility & Grounds	11,550		34.5
Rent - Equipment	247		35.5

3 Reclassification C.N.A. Training Expenses for Trainers/Trainees

C.N.A. Training	72,217		13.5
Nursing & Medical Records		(71,309)	10.5
Activities		(20)	11.5
Housekeeping		(19)	3.5
Other - Edu/Day Training		(869)	43.5

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(15,992)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(70,128)	32		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	(917)	20		18
19	Entertainment	(460)	24		19
20	Contributions	(150)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(28,625)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,589)	27		24
25	Fund Raising, Advertising and Promotional	(26,827)	20		25
	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	(40,032)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (186,720)		\$	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)	(204,037)	17, 19	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (204,037)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (390,757)		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

STATE OF ILLINOIS
Exceptional Care & Training Center

Page 5A

ID# 0035477
Report Period Beginning: 07/01/2011
Ending: 06/30/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Miscellaneous Income	\$ (21,599)	21	1
2	Unallowable Fundraising Expense	(706)	21	2
3	Amortization of Bond Acq Costs not Facility-Related	(2,074)	36	3
4	Unallowable Cable TV Expense	(95)	5	4
5	Unallowable Auto Expense in Excess of 1 limit	(100)	24	5
6	Unallowable Auto Expense (Depr)	(13,716)	30	6
7	Unallowable Lobbying Portion of ILHCA Dues	(1,742)	20	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(40,032)		49

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

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	<u>Corporate Group Overhead</u>	<u>\$ 175,934</u>	<u>Hoosier Care, Inc.</u>	<u>100.00%</u>	<u>\$ 158,501</u>	<u>\$ (17,433)</u>	1
2	V				<u>Note: Please see Schedule VIII for Allocation of Col. 7 Amt</u>				2
3	V								3
4	V	19	<u>Rel. Party Management Fee</u>	<u>460,800</u>	<u>Medical Rehabilitation Centers, LLC</u>	<u>25.00%</u>	<u>274,196</u>	<u>(186,604)</u>	4
5	V				<u>dba Exceptional Living Centers</u>				5
6	V				<u>Hoosier Care owns 25% of the beneficial interests of MRC</u>				6
7	V				<u>Note: Please see Schedule VIII for Allocation of Col. 7 Amt</u>				7
8	V								8
9	V	17	<u>Hoosier Care Investments, LLC</u>	<u>46,352</u>	<u>Hoosier Care, Inc. is a member of Hoosier Care Investments,</u>	<u>N/A</u>	<u>46,352</u>		9
10	V				<u>LLC., a Not-for-Profit company which provides oversight,</u>				10
11	V				<u>corporate governance and administrative services for</u>				11
12	V				<u>all of Hoosier Care's affiliated facilities.</u>				12
13	V								13
14	Total			<u>\$ 683,086</u>			<u>\$ 479,049</u>	<u>\$ * (204,037)</u>	14

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

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 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	Lew Wood, Jr.	Board Member	Governance	0%							6
7	Stephen Wood	Board Member	Governance	0%							7
8	Fees are paid by Hoosier Care to Hoosier Care Investments, LLC (HCI), which go toward, among other things solely within the										8
9	control of HCI, fees for members of the Boards of Directors of HCI affiliated facilities, Exceptional Care & Training Center										9
10	being only one of many. The total amount included on Line 17 of this Cost Report, through the Hoosier Care allocation of										10
11	indirect costs, is disclosed here. Amounts paid by other facilities are shown on Page 7.1										11
12								Fees	46,352	17.8	12
13								TOTAL	\$ 46,352		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

STATE OF ILLINOIS

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

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 Board / Administration Fees by other Nursing Homes

Walter Lawson Children's Home	61,504
Swann Special Care Center	69,567
Exceptional Care & Training Center	46,352
Vernon Manor Children's Home	44,860
Exceptional Living Center of Brazil	52,361
Richland-Bean Blossom Health Care	34,729
Randolph Nursing Home	36,103

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/2011 Ending: 6/30/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Heat & Other Utilities	Direct Costs	48,917,933	7	\$ 4,598	\$	6,563,303	\$ 617	1
2	6	Maintenance	Direct Costs	48,917,933	7	4,220		6,563,303	566	2
3	17	Administration	Direct Costs	48,917,933	7	345,476		6,563,303	46,352	3
4	19	Professional Services	Direct Costs	48,917,933	7	330,303	87,296	6,563,303	44,317	4
5	20	Dues, Fees, Subscriptions	Direct Costs	48,917,933	7	241,007		6,563,303	32,336	5
6	21	Clerical & General Office Exp	Direct Costs	48,917,933	7	85,092	66,386	6,563,303	11,417	6
7	22	Emp. Benefits & Payroll Tax	Direct Costs	48,917,933	7	50,777		6,563,303	6,813	7
8	24	Travel & Seminar	Direct Costs	48,917,933	7	17,342		6,563,303	2,327	8
9	26	Insurance	Direct Costs	48,917,933	7	(273)		6,563,303	(37)	9
10	30	Depreciation	Direct Costs	48,917,933	7	1,712		6,563,303	230	10
11	32	Interest Expense	Direct Costs	48,917,933	7	89,484		6,563,303	12,006	11
12	34	Rent - Facility	Direct Costs	48,917,933	7	7,150		6,563,303	959	12
13	35	Rent - Equipment	Direct Costs	48,917,933	7	623		6,563,303	84	13
14	36	Other (Amortization)	Direct Costs	48,917,933	7	3,830		6,563,303	514	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,181,341	\$ 153,682		\$ 158,501	25

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/2011 Ending: 6/30/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Medical Rehabilitation Centers, LLC
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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Direct Costs	89,405,466	15	\$ 2,889	\$	6,563,303	\$ 212	1
2	19	Professional Services	Direct Costs	89,405,466	15	87,754		6,563,303	6,442	2
3	20	Dues, Fees, Subscriptions	Direct Costs	89,405,466	15	122,430		6,563,303	8,988	3
4	21	Clerical & General Office	Direct Costs	89,405,466	15	3,017,945	3,017,945	6,563,303	221,549	4
5	22	Employee Benefits & Payroll Tax	Direct Costs	89,405,466	15	31,204		6,563,303	2,291	5
6	23	Inservice Training & Education	Direct Costs	89,405,466	15	14,123		6,563,303	1,037	6
7	24	Travel & Seminar	Direct Costs	89,405,466	15	140,877		6,563,303	10,342	7
8	26	Insurance	Direct Costs	89,405,466	15	75,692		6,563,303	5,557	8
9	30	Depreciation	Direct Costs	89,405,466	15	81,475		6,563,303	5,981	9
10	34	Rent - Facility & Grounds	Direct Costs	89,405,466	15	157,333		6,563,303	11,550	10
11	35	Rent - Equipment	Direct Costs	89,405,466	15	3,367		6,563,303	247	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					\$ 3,735,089	\$ 3,017,945		\$ 274,196	25

Facility Name & ID Number	Exceptional Care & Training Center	# 0035477	Report Period Beginning:	07/01/2011	Ending:	06/30/2012
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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	City of Sterling Bonds 1999A		X	Purchase of Facility	Varies	07/08/99	\$ 4,775,000	\$ 4,105,000	06/01/34	0.0713	\$ 296,089	1	
2	City of Sterling Bonds 1999B		X	Purchase of Facility	Varies	07/08/99	220,000	130,000	06/02/19	0.0105	14,394	2	
3												3	
4												4	
5												5	
	Working Capital												
6	Group Allocation		X	Working Capital	Varies	10/27/11	5,000,000	Varies	10/27/14	Varies	12,006	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 9,995,000	\$ 4,235,000			\$ 322,489	9	
	B. Non-Facility Related*												
10	Group Debt Allocation		X	Alloc of Group Debt / Former F	Varies	07/08/99	1,041,923	956,581	Varies	Varies	70,128	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$ 1,041,923	\$ 956,581			\$ 70,128	14	
15	TOTALS (line 9+line14)						\$ 11,036,923	\$ 5,191,581			\$ 392,617	15	

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

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

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

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

B. Real Estate Taxes

	Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2011 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 2012 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:	2007		8
	2008		9
	2009		10
	2010		11
	2011		12
<u>Note: This facility became exempt from Property Taxes starting on 1/1/1996</u>			

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Exceptional Care & Training Center

COUNTY

Whiteside

FACILITY IDPH LICENSE NUMBER

0035477

CONTACT PERSON REGARDING THIS REPORT

Joe Guillory

TELEPHONE

859-317-4040

FAX #:

859-281-5150

A.
Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

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

☐

(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

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

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

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

None.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	SNF / PED	63,598	1989	\$ 414,085	1
2					2
3	TOTALS	63,598		\$ 414,085	3

HFS 3745 (N-4-99)

IL478-2471

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	64		1989		\$ 2,334,000	\$ 58,000	10-35	\$ 58,000	\$	\$ 1,633,166	4
5	15			1991	358,311	11,944	30	11,944		251,376	5
6	5			2004							6
7											7
8											8
	Improvement Type**										
9	MAJOR BOILER REPAIR			1990	964		10			964	9
10	REPLACE WATER UNIT			1991	8,780		10			8,780	10
11	XFORMERS/PA SYSTEM - TECT			1991	696		10			696	11
12	BLDG ADDTN DRYWALL - INST			1991	403		10			403	12
13	CLOSET CURTAIN TRACK-GM C			1991	650		10			650	13
14	DOOR - C&E GLASS			1991	1,614		10			1,614	14
15	BOILER VALVE -SCHMIDT			1992	803		10			803	15
16	HEAT EXCHANGER/BOILER-SCH			1992	1,315		10			1,315	16
17	DRAIN REPLACEMENT/GBG DIS			1992	1,576		10			1,576	17
18	REPLACE HEAT EXCHANGER-SC			1992	4,062		10			4,062	18
19	STORM WINDOWS - C&E GLASS			1992	907		10			907	19
20	BOILER TUBES - SCHMIDT PL			1992	7,147		10			7,147	20
21	ROOF - HAUS BLDRS			1992	11,118		10			11,118	21
22	KITCHEN TILE SCHMIDT & AS			1992	3,660		10			3,660	22
23	SHED			1992	1,678		10			1,678	23
24	GATE & FENCE SCARS			1992	4,038		10			4,038	24
25	LANDSCAPING MEGLI LAWN CA			1992	2,397		10			2,397	25
26	HEATING & COOLING UNIT SC			1992	7,757		10			7,757	26
27	LIGHT FIXTURES			1992	3,743		10			3,743	27
28	BUILDING RENOVATION			1992	139	5	30	5		93	28
29	PAINT NEW LAUNDRY ROOM			1992	351		10			351	29
30	BLACKTOP WORK			1992	575		10			575	30
31	PAINT NEW LAUNDRY ROOM			1993	262		10			262	31
32	INSTALL TILE			1993	730		10			730	32
33	BUILDING RENOVATION/REMOD			1993	7,105		10			7,105	33
34	ELECTRICAL WORK			1993	3,255		10			3,255	34
35	INSTALL PIPE/WIRE FOR LAU			1993	156		10			156	35
36	INSTALL TILE			1993	290		10			290	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Exceptional Care & Training Center

0035477

Report Period Beginning:

07/01/2011

Ending:

06/30/2012

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	RENOVATE WATER HEATER	1993	\$ 849	\$	10	\$	\$	\$ 849	37
38	FINAL PMT ON LAUNDRY PROJ	1993	1,030		10			1,030	38
39	SEAL AND RESTRIPE PARKING	1993	1,800		10			1,800	39
40	INSTALL NEW SEWER LINES	1993	4,105		10			4,105	40
41	REPLACE RELAY IN PANEL	1993	1,149		10			1,149	41
42	NEW WATER MAIN	1993	12,204		10			12,204	42
43	REPLACE PARTS ON 2 SUMP P	1994	4,034		10			4,034	43
44	INSTALLED BACKFLOW PREVEN	1994	1,053		10			1,053	44
45	LG TOILET SUPPORT,BACK &	1994	923		10			923	45
46	DECK	1994	814		10			814	46
47	COUNTERTOP	1995	527		10			527	47
48	NEW ROOF	1995	29,435		10			29,435	48
49	TILE FOR FLOORS IN TUB RO	1995	4,405		10			4,405	49
50	THERMOCOUPLE ON BOILER	1995	2,550		10			2,550	50
51	NEW PUMP ON BOILER SYSTEM	1995	1,706		10			1,706	51
52	LANDSCAPING	1995	15,000		10			15,000	52
53	AIR CONDITIONER COMPRESSO	1995	1,668		10			1,668	53
54	REPLACE FIRE ALARM	1995	3,743		10			3,743	54
55	REBUILD WATER SOFTENER	1995	1,880		10			1,880	55
56	NEW DOOR & FRAME INSTALLE	1995	959		10			959	56
57	REBUILD CORNER OF BUILDIN	1996	2,000		10			2,000	57
58	INSTALL TWO BELL-STROBES	1996	888		10			888	58
59	REPLACE RELAY ON GENERATO	1996	1,325		10			1,325	59
60	REPL 3/4HP MOTOR,THERMOCO	1996	920		10			920	60
61	REPL BOILER PUMPS,BEARING	1997	640		10			640	61
62	INSTALL 3/4HP MOTOR-BOILE	1997	725		10			725	62
63	REPL CIRCULATING PUMP,BEA	1997	743		10			743	63
64	TWENTY NEW WATER FAUCETS	1997	2,296		10			2,296	64
65	VINYL FLOOR TILE-RESIDENT	1997	690		10			690	65
66	RESEAL PARKING AREA	1997	2,845		10			2,845	66
67	AIR CONDITIONING CONDENSE	1997	1,650		10			1,650	67
68	INSTALL CONDUIT;MORE AMPE	1997	913		10			913	68
69	REPLACE OUTLETS/WIRING RE	1997	522		10			522	69
70	TOTAL (lines 4 thru 69)		\$ 2,874,475	\$ 69,949		\$ 69,949	\$	\$ 2,066,660	70

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

Facility Name & ID Number Exceptional Care & Training Center

0035477

Report Period Beginning:

07/01/2011 Ending: 06/30/2012

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,874,475	\$ 69,949		\$ 69,949	\$	\$ 2,066,660	1
2	REPLACE KITCHEN FIRE SYST	1998	767		10			767	2
3	REPLACED SMOKE DETECTORS	1998	621		10			621	3
4	INSTALL ANSIL SYS PIPE/WI	1998	995		10			995	4
5	REPLACED SIX SMOKE DETECT	1998	1,645		10			1,645	5
6	PART:GENERATOR,TRANSFER S	1998	2,746		10			2,746	6
7	TANK REPLACEMENT - PIPECO	1998	9,890	495	20	495		6,841	7
8	BOILER CONTROL;SWITCH: LI	1998	709		10			709	8
9	REPLACE FAULTY SMOKE DETE	1998	973		10			973	9
10	TUBES-BOILER;PIPES-WATER	1998	1,690		10			1,690	10
11	INSTALL TILE:WALLS,STAIRC	1998	4,495		10			4,495	11
12	2 HOT WATER TANKS	1999	7,119		10			7,119	12
13	INSTALL HEAVY ELEC.SERVIC	1999	1,651		10			1,651	13
14	COOLING SYSTEM-LAUNDRY/KI	2000	4,650	233	20	233		2,906	14
15	PLASTER/DRYWALL RESIDENT	2000	800		10			800	15
16	NEW TILE IN DINING RM/CLA	2000	4,770	318	15	318		3,896	16
17	INSTALL THERMOCOUPLE-W. B	2000	353		10			353	17
18	REPL THERMOCOUPLE ON W.BO	2000	140		10			140	18
19	REPL THERMOCOUPLE-INDUCER	2000	215		10			215	19
20	REBUILT 2 HOPPER VALVES;R	2000	1,430		10			1,430	20
21	REPL COUPLER,MOTOR,BEARIN	2000	298		10			298	21
22	INSTALLATION OF NEW DOOR	2000	583		10			583	22
23	REPL BEARING ASSY-WATER L	2000	518		10			518	23
24	INDICATOR LAMPS & VOLTAGE	2000	1,525		10			1,525	24
25	REPLACED HEAT EXCHANGER.	2001	962		10			962	25
26	RENNOVATION INSTALLMENT.	2001	63,363		5			63,363	26
27	REPLACE HEAT EXCHANGER.	2001	962		10			962	27
28	REPLACE DRAFT INDUCER ON	2001	1,414		10			1,414	28
29	REPLACE PIPE.	2001	530		10			530	29
30	CONCRETE FOR CANAPY & ADD	2001	2,592		5			2,592	30
31	REPLACE CLINICAL SINK AND	2001	2,304	154	15	154		1,728	31
32	FURNISH & INSTALL AWNING.	2001	2,771	185	15	185		2,079	32
33	LABOR & MAT-BREAKER PANEL	2001	3,930	262	15	262		2,947	33
34	TOTAL (lines 1 thru 33)		\$ 3,001,887	\$ 71,594		\$ 71,594	\$	\$ 2,186,153	34

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

Facility Name & ID Number Exceptional Care & Training Center

0035477

Report Period Beginning:

07/01/2011 Ending: 06/30/2012

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,001,887	\$ 71,594		\$ 71,594	\$	\$ 2,186,153	1
2	INSTALL THERMO COUPLE ON	2001	944		10			944	2
3	EXCAVATION OF NEW PARKING	2001	12,415	621	20	621		6,932	3
4	Install elect. for dishwa	2001	820	55	15	55		611	4
5	REROOF FACILITY AND GARAG	2001	13,960	558	25	558		6,235	5
6	LUSTERBOARD SIGN	2001	515		5			515	6
7	REFUND-ELECTRICAL PANEL	2001	-975		5			-975	7
8	INSTALL WATER HEATER	2001	3,341	223	15	223		2,450	8
9	CONDUIT & WIRING FOR DOOR	2001	1,982	132	15	132		1,454	9
10	AIR CONDITIONING IN LOBBY	2001	349	3	10	3		349	10
11	EAST TUB ROOM FAN MOTOR R	2001	213	2	10	2		213	11
12	DRYER VENT REPLACED	2001	319	3	10	3		319	12
13	WALKWAY	2001	4,119	275	15	275		2,998	13
14	RECONFIGURE WANTER HEATER	2001	1,860	124	15	124		1,343	14
15	RECONFIGURE CHANGING AREA	2001	3,393		5			3,393	15
16	REPLACE BREAKER, BALASTS	2002	555		5			555	16
17	TENNANT ALLOWANCE TO OFFS	2002	-5,000		5			-5,000	17
18	INSTALL TEMP CONTROL CART	2002	537	36	15	36		376	18
19	INTERNET SET-UP-WIRING CA	2002	3,061	204	15	204		2,125	19
20	MOTOR BOILER	2002	763	51	10	51		763	20
21	RAILING ON STAIRS TO PARK	2002	2,130	142	15	142		1,455	21
22	REPLACE METAL DOOR	2002	1,665	111	15	111		1,119	22
23	SHUTTERS	2002	820	75	10	75		820	23
24	PRIVACY FENCE	2002	2,550	234	10	234		2,550	24
25	STORM WINDOW PROJECT	2002	8,937	447	20	447		4,506	25
26	NEW MOTOR ON BOILER 1	2002	962	96	10	96		962	26
27	INSTALLED HOSPITAL OUTLET	2002	2,256	226	10	226		2,237	27
28	SIDE SCREENS ON DT AWNING	2003	738		5			738	28
29	WIRING FOR NEW TIME CLOCK	2003	634	63	10	63		586	29
30	MOTOR & COUPLER/CIRCUL PU	2003	835	83	10	83		772	30
31	Anne's Landscaping	2004	590	59	10	59		482	31
32	Fire & Electric system (part of 298)	2004	435	5	7	5		435	32
33	Day Training Addition	2004	346,465	11,549	30	11,549		90,466	33
34	TOTAL (lines 1 thru 33)		\$ 3,414,073	\$ 86,970		\$ 86,970	\$	\$ 2,318,881	34

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

Facility Name & ID Number Exceptional Care & Training Center

0035477

Report Period Beginning:

07/01/2011

Ending:

06/30/2012

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,414,073	\$ 86,970		\$ 86,970	\$	\$ 2,318,881	1
2	New Electrical System (Mulit Purpose Rm +)	2004	6,637	158	7	158		6,637	2
3	Parking Lot Renovation	2004	3,499	350	10	350		2,703	3
4	conduit and wire hookup	2004	965	97	10	97		732	4
5	34 heat/smoke detectors	2004	2,800	167	7	167		2,800	5
6	Commerical disposal	2005	551	39	7	39		551	6
7	18 kickplates	2005	2,215	222	10	222		1,643	7
8	hollow metal door	2005	945	63	15	63		446	8
9	3 ACU124PM air conditioners	2005	1,755	251	7	251		1,755	9
10	replace compressor in lobby	2005	11,445	763	15	763		5,277	10
11	2 new A/C units	2005	1,170	167	7	167		1,142	11
12	install pull station/light/speaker	2005	1,434	143	10	143		968	12
13	replace mixing valve for hot water	2005	1,168	117	10	117		779	13
14	replace booster pump/shower head	2005	943	94	10	94		621	14
15	New roof	2006	15,987	1,599	10	1,599		10,125	15
16	Water heater	2006	4,717	472	10	472		2,830	16
17	A/C units for bedrooms (3)	2006	1,755	251	7	251		1,504	17
18	Sprinkler system-Phase I	2006	33,165	2,211	15	2,211		13,266	18
19	Sprinkler system-Phase II	2006	7,920	528	15	528		3,168	19
20	Fire door for tub room	2006	640	64	10	64		384	20
21	Sprinkler system-Phase III	2006	13,365	891	15	891		5,123	21
22	Sprinkler system-phase IV	2006	1,978	132	15	132		736	22
23	Light fixtures (24) and new wiring	2007	6,434	429	15	429		2,323	23
24	Ductwork & roof exhaust for new dryer	2007	3,498	233	15	233		1,244	24
25	Raise sidewalks	2007	950	95	10	95		475	25
26	Air conditioning window units (2)	2007	1,170	167	7	167		836	26
27	Door assembly for boiler	2007	1,072	107	10	107		536	27
28	Brake assembly on dumbwaiter	2007	4,389	293	15	293		1,439	28
29	Tile walls in classrooms 1-4, 8	2008	9,300	620	15	620		2,738	29
30	Pistons & gears for water softner system	2008	947	95	10	95		403	30
31	Privacy wall in day rooms (2)	2008	3,297	220	15	220		898	31
32	A/C wall units (4)	2008	1,841	184	10	184		721	32
33	5 ton a/c compressor	2008	2,000	200	10	200		783	33
34	TOTAL (lines 1 thru 33)		\$ 3,564,025	\$ 98,389		\$ 98,389	\$	\$ 2,394,467	34

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

Facility Name & ID Number Exceptional Care & Training Center

0035477

Report Period Beginning:

07/01/2011 Ending: 06/30/2012

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,564,025	\$ 98,389		\$ 98,389	\$	\$ 2,394,467	1
2	Smoke detectors (5)	2008	1,631	163	10	163		625	2
3	Cabinets for south day room	2008	908	61	15	61		232	3
4	Wiring & outlets for kitchen & dayrooms	2008	3,434	229	15	229		858	4
5	Portions of parking lot replaced/resurfaced	2008	3,670	367	10	367		1,346	5
6	Circulating pump for kitchen	2008	678	68	10	68		248	6
7	Boiler ventilation motor delay switch	2008	1,716	172	10	172		615	7
8	Exit & boiler room doors replaced	2008	2,712	181	15	181		633	8
9	Aquastat replaced on boiler	2008	533	53	10	53		187	9
10	Sewage pump	2009	4,133	413	10	413		1,412	10
11	Bearings for hot water circulating pump	2009	736	49	15	49		164	11
12	Hot water circulation pump	2009	517	52	10	52		164	12
13	Cabinets & counter for edu bldg kitchen	2009	1,162	77	15	77		238	13
14	Avaya phone system for day training	2009	7,010	701	10	701		2,161	14
15	Remodel employee/public restrooms (2)	2009	1,722	172	10	172		517	15
16	Convert 2 classrooms to 1 & remodel restroom	2009	2,846	190	15	190		569	16
17	Electrical outlets for food service	2009	1,419	95	15	95		284	17
18	5 ton rooftop hvac unit	2009	6,485	432	15	432		1,297	18
19	26 x 12 storage shed	2009	8,280	552	15	552		1,656	19
20	Concrete sidewalk for emergency exit	2009	7,119	475	15	475		1,384	20
21	Cabinets for education bldg	2009	562	37	15	37		109	21
22	Water heaters (2)	2009	11,250	1,125	10	1,125		3,281	22
23	Fire damper for laundry air intake	2009	1,452	97	15	97		274	23
24	Trex security fence	2009	9,142	609	15	609		1,676	24
25	Induct air purifiers (5)	2009	1,690	169	10	169		437	25
26	Shaft for boiler exhaust	2010	512	51	10	51		128	26
27	Steel roll-up door for dumpster enclosure	2010	1,399	140	10	140		338	27
28	Rpl parts on rooftop RTUs	2010	1,737	174	10	174		420	28
29	Bearing assembly for hot water pump in kitche	2010	522	52	10	52		118	29
30	Grease trap replaced and electric & tile repa	2010	7,217	481	15	481		1,002	30
31	Roof for courtyard pavillion	2010	6,657	444	15	444		925	31
32	120 volt electrical outlet for air purifiers	2010	781	52	15	52		108	32
33	Remodel pavillion	2010	759	76	10	76		152	33
34	TOTAL (lines 1 thru 33)		\$ 3,664,414	\$ 106,398		\$ 106,398	\$	\$ 2,418,024	34

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

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 12E, Carried Forward		\$ 3,664,414	\$ 106,398		\$ 106,398	\$	\$ 2,418,024	1
2	Tile work for walls in south & east halls	2010	11,594	1,159	10	1,159		2,319	2
3	Misc electrical work	2010	4,915	328	15	328		573	3
4	Main drain line replaced	2010	2,818	188	15	188		329	4
5	Parapet wall on roof	2010	8,215	411	20	411		685	5
6	Greenhouse for therapy use	2010	12,475	1,247	10	1,247		1,871	6
7	Hot water circulating pump	2011	2,457	246	10	246		328	7
8	Remodel restroom for isolation room	2011	2,556	256	10	256		341	8
9	Convert dayroom to culinary arts center	2011	721	72	10	72		96	9
10	Electric keypad door opener	2011	598	60	10	60		70	10
11	Hot water mixing valve	2011	1,200	120	10	120		130	11
12	Rentention pond	2011	7,273	727	10	727		788	12
13	Hardscape & landscape for rentention pond	2011	3,936	394	10	394		426	13
14	Vinyl coated chain link fence	2011	6,475	648	10	648		701	14
15	Tile in lobby and surrounding areas	2011	3,274	327	10	327		355	15
16	Retrofit 3 windows for a/c units	2011	951	87	10	87		87	16
17	Concrete pads for courtyard (4)	2011	900	83	10	83		83	17
18	Replace sidewalks	2011	6,617	496	10	496		496	18
19	Roof hvac units (2)	2011	8,173	613	10	613		613	19
20	Water heater for south wing	2011	7,937	595	10	595		595	20
21	Push bar and latch for south exit door	2011	752	50	10	50		50	21
22	Replace header on basement door	2011	4,870	189	15	189		189	22
23	Magnetic Alarm Fire Door Holders & Install	2011	1,059	62	10	62		62	23
24	Greenhouse Heater/AirSystem & assembly	2011	1,725	123	7	123		123	24
25	Hot water circulating pump for boiler	2012	562	23	10	23		23	25
26	20 amp circuits added to generator line (7)	2012	1,550	52	10	52		52	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,768,018	\$ 114,954		\$ 114,954	\$	\$ 2,429,410	34

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

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	\$341,371	\$64,957	\$64,957	\$	3-10	\$164,808	71
72	Current Year Purchases	36,930	17,155	17,155		3-7	4,079	72
73	Fully Depreciated Assets	561,230				3-15	561,230	73
74								74
75	TOTALS	\$939,531	\$82,112	\$82,112	\$		\$730,117	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	\$3,439	\$	\$(3,439)	5	\$3,439	76
77										77
78										78
79										79
80	TOTALS			\$41,267	\$3,439	\$	\$(3,439)		\$3,439	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$5,162,90181
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$200,50582
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$197,06683**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(3,439)84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,162,96685

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	Vehicles in Excess of 1 Allowed	\$171,100	\$13,716	\$78,757	86
87					87
88					88
89					89
90					90
91	TOTALS	\$171,100	\$13,716	\$78,757	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Corpoate Group Allocations		N/A		12,509			5
6								6
7	TOTAL				\$ 12,509			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
- N/A
- .

9. Option to Buy:
- ☐ YES
- ☒ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO
16. Rental Amount for movable equipment: \$ 5,095
- Description: See attached Schedule 14.1
- (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

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

XII. RENTAL COSTS

16. Rental Amount for movable equipment: \$

5,095

Description: See below for detailed breakdown

(Attach a schedule detailing the breakdown of mo

Vendor	Description	Amount
Pitney Bowes	Postage Machine Rental	\$ 184.00
Pitney Bowes	Postage Machine Rental	\$ 184.00
Pitney Bowes	Postage Machine Rental	\$ 184.00
Pitney Bowes	Postage Machine Rental	\$ 184.00
OCE Imagistics	Copier Lease	\$ 346.68
OCE Imagistics	Copier Lease	\$ 346.68
OCE Imagistics	Copier Lease	\$ 346.68
OCE Imagistics	Copier Lease	\$ 346.68
OCE Imagistics	Copier Lease	\$ 346.68
OCE Imagistics	Copier Lease	\$ 337.00
OCE Imagistics	Copier Lease	\$ 337.00
OCE Imagistics	Copier Lease	\$ 346.68
OCE Imagistics	Copier Lease	\$ 337.00
OCE Imagistics	Copier Lease	\$ 230.22
OCE Imagistics	Copier Lease	\$ 246.25
OCE Imagistics	Copier Lease	\$ 230.22
OCE Imagistics	Copier Lease	\$ 230.22
TOTAL ECTC		\$ 4,764
HOOSIER CARE & MRC GROUP ALLOCATIONS:		\$ 331
TOTAL LINE XII.B.16		\$ 5,095

: 07/01/2011 Ending: 06/30/2012

vable equipment)

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
☐ 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 CNA50

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☒
IN OTHER FACILITY☐
HOURS PER CNA80

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)		27,331		27,331
4	Clinical Wages (b)		43,729		43,729
5	In-House Trainer Wages (c)		1,158		1,158
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 72,218	\$	\$ 72,218
10	SUM OF line 9, col. 1 and 2 (e)	\$ 72,218			

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	47
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	47

(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.

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.3	# of prescrpts			3,784	3,862		7,646	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	39.3	hrs			10,215			10,215	10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$ 13,999	\$ 3,862		\$ 17,861	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.

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	\$ 5,810	\$	1
2	Cash-Patient Deposits	68,601		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (3,589))	1,885,486		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,341		6
7	Other Prepaid Expenses	30,838		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Corporate	12,526,673		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 14,529,749	\$	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	3,703,352		14
15	Leasehold Improvements, at Historical Cost	64,666		15
16	Equipment, at Historical Cost	1,151,900		16
17	Accumulated Depreciation (book methods)	(3,241,724)		17
18	Deferred Charges	246,638		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	471,865		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Goodwill	396,154		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,206,936	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 17,736,685	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 139,466	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	68,601		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	221,698		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,000		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	31,273		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 473,038	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,191,581		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,191,581	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,664,619	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 12,072,066	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 17,736,685	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 11,651,917	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 11,651,917	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	420,149	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)	\$ 420,149	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)	\$ 12,072,066	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Exceptional Care & Training Center# 0035477Report Period Beginning: 07/01/2011Ending: 06/30/2012

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.

	1		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,290,850	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,290,850	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	38,443	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)	\$ 38,443	23
	D. Non-Operating Revenue		
24	Contributions	13,463	24
25	Interest and Other Investment Income***	15,992	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 29,455	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Day Training</u>	1,603,090	28
28a	<u>Miscellaneous Income</u>	21,599	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,624,689	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,983,437	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	907,640	31
32	Health Care	2,255,453	32
33	General Administration	1,638,686	33
	B. Capital Expense		
34	Ownership	597,730	34
	C. Ancillary Expense		
35	Special Cost Centers	852,717	35
36	Provider Participation Fee	311,062	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,563,288	40
41	Income before Income Taxes (line 30 minus line 40)**	420,149	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 420,149	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 5,267,850	44
45	Private Pay - Net Inpatient Revenue	23,000	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)	\$ 5,290,850	49

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

** Does this agree with taxable income (loss) per Federal Income

Tax Return? _____ If not, please attach a reconciliation.

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

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

Facility Name & ID Number Exceptional Care & Training Center# 0035477Report Period Beginning: 07/01/2011Ending: 06/30/2012

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,861	2,055	\$ 65,492	\$ 31.87	1
2	Assistant Director of Nursing	1,864	2,100	65,592	31.23	2
3	Registered Nurses	5,313	5,782	139,639	24.15	3
4	Licensed Practical Nurses	18,966	20,495	443,868	21.66	4
5	CNAs & Orderlies	82,387	89,479	1,059,161	11.84	5
6	CNA Trainees					6
7	Licensed Therapist	156	165	11,742	71.16	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,743	2,053	42,181	20.55	9
10	Activity Assistants	17,326	19,017	207,872	10.93	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,714	1,850	33,140	17.91	13
14	Head Cook	5,516	5,975	76,029	12.72	14
15	Cook Helpers/Assistants	6,520	6,952	63,537	9.14	15
16	Dishwashers					16
17	Maintenance Workers	3,054	3,266	49,223	15.07	17
18	Housekeepers	12,191	13,412	165,480	12.34	18
19	Laundry	11,269	12,363	150,298	12.16	19
20	Administrator	2,091	2,260	119,713	52.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,124	5,643	100,626	17.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	6,812	7,359	121,182	16.47	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	105	116	2,490	21.47	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Day Training</u>	42,690	46,321	566,337	12.23	33
34	TOTAL (lines 1 - 33)	226,702	246,663	\$ 3,483,602 *	\$ 14.12	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	N/A	\$ 5,381	1.3	35
36	Medical Director	N/A	21,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant	N/A	22,036	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	N/A	7,565	10a.3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>IT & Cost Report Consulting</u>	N/A	10,367	21.3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 66,349		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

[illegible]

*** Attach copy of IMRF notifications**

****See instructions.**

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													
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14													
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16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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, \$4,678 (Gross before 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. \$ 24,000 Line 10.2

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

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

(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. \$ 311,062
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? N/A 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? N/A Indicate the amount. \$ N/A

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

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

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