

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: <u>0035477</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>Exceptional C & Training Ctr</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2015</u> to <u>06/30/2016</u> 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.																																																	
Address: <u>2601 Woodlawn Road</u> <u>Sterling</u> <u>61081</u>																																																			
Number City Zip Code																																																			
County: <u>Whiteside</u>																																																			
Telephone Number: <u>(815) 626-8520</u> Fax # <u>(815) 626-8075</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: <u>08/15/1989</u>																																																			
Type of Ownership:																																																			
<table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code <u>501(c)(3)</u></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2"></td></tr></table>		☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code <u>501(c)(3)</u>		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	_____				☐	Limited Liability Co.	_____				☐	Trust					☐	Other _____				
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		☐	Trust																																																
		☐	Other _____																																																
In the event there are further questions about this report, please contact:																																																			
Name: <u>Joe Guillory</u>																																																			
Telephone Number: <u>(859) 255-0075</u>																																																			
Email Address: _____																																																			
		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) <u>09/30/2016</u></td></tr><tr><td rowspan="6">Paid Preparer</td><td>(Type or Print Name) <u>Joseph Guillory</u></td></tr><tr><td>(Title) <u>Designated Agent</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td colspan="2">(Telephone) <u>()</u> Fax # <u>()</u></td></tr><tr><td colspan="2">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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) <u>09/30/2016</u>	Paid Preparer	(Type or Print Name) <u>Joseph Guillory</u>	(Title) <u>Designated Agent</u>	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>		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																																			
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Facility Name & ID Number Exceptional C & Training Ctr

0035477 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED	29,718		11	29,729	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,718		11	29,729	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.70%

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

42 (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 ☒

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 08/15/1989 NO ☐

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: FYE 6/30/2016 Fiscal Year: FYE 6/30/2016

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

Facility Name & ID Number Exceptional C & Training Ctr # 0035477 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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

	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	161,411	10,205	7,390	179,006		179,006	(41,862)	137,144			1
2	Food Purchase		187,005		187,005		187,005	(43,732)	143,273			2
3	Housekeeping	164,694	17,115		181,809		181,809	(48,073)	133,736			3
4	Laundry	144,018	15,168		159,186		159,186		159,186			4
5	Heat and Other Utilities			73,550	73,550		73,550	1,824	75,374			5
6	Maintenance	43,108	20,671	38,927	102,706		102,706	(20,797)	81,909			6
7	Other (specify):*											7
8	TOTAL General Services	513,231	250,164	119,867	883,262		883,262	(152,640)	730,622			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	1,780,763	145,861	609	1,927,233	(87,448)	1,839,785	(233,045)	1,606,740			10
10a	Therapy	16,777	501	8,200	25,478		25,478	(8,368)	17,110			10a
11	Activities	246,629	2,001		248,630		248,630		248,630			11
12	Social Services											12
13	CNA Training					87,448	87,448		87,448			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,044,169	148,363	29,809	2,222,341		2,222,341	(241,413)	1,980,928			16
	C. General Administration											
17	Administrative	135,449			135,449		135,449	73,037	208,486			17
18	Directors Fees			78,864	78,864		78,864	(21,245)	57,619			18
19	Professional Services			431,934	431,934		431,934	(373,851)	58,083			19
20	Dues, Fees, Subscriptions & Promotions			75,956	75,956		75,956	(32,530)	43,426			20
21	Clerical & General Office Expenses	72,965	12,453	46,800	132,218		132,218	(62,920)	69,298			21
22	Employee Benefits & Payroll Taxes			546,962	546,962		546,962	(94,301)	452,661			22
23	Inservice Training & Education			16,373	16,373		16,373	(6,581)	9,792			23
24	Travel and Seminar			5,576	5,576		5,576	16,100	21,676			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			37,251	37,251		37,251	21,737	58,988			26
27	Other (specify):*			(881)	(881)		(881)	881				27
28	TOTAL General Administration	208,414	12,453	1,238,835	1,459,702		1,459,702	(479,673)	980,029			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,765,814	410,980	1,388,511	4,565,305		4,565,305	(873,726)	3,691,579			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							207,794	207,794			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,745	4,745		4,745	163,941	168,686			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			484,554	484,554		484,554	(478,909)	5,645			34
35	Rent-Equipment & Vehicles			6,270	6,270		6,270	(1,335)	4,935			35
36	Other (specify):* MIP							31,024	31,024			36
37	TOTAL Ownership			495,569	495,569		495,569	(77,485)	418,084			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		9,369	20,770	30,139		30,139	(10,675)	19,464			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			316,705	316,705		316,705		316,705			42
43	Other (specify):* Direct GL DT exp	656,588		130,302	786,890		786,890	(786,889)	1			43
44	TOTAL Special Cost Centers	656,588	9,369	467,777	1,133,734		1,133,734	(797,564)	336,170			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,422,402	420,349	2,351,857	6,194,608		6,194,608	(1,748,775)	4,445,833			45

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

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		2,862.72
Silverchair Learning Systems Core Curriculum Education Software Quarterly Bill - billing for October - December	All Employees		2,862.72
Silverchair Learning Systems Core Curriculum Education Software Quarterly Bill - billing for January - March	All Employees		3,091.74
Silverchair Learning Systems Core Curriculum Education Software Quarterly Bill - billing for April - June	All Employees		3,091.74
B. Williams Enterprise LLC Employee Service & Leadership Training	All Employees		618.00
Conni Holder CPR/FA Training Sessions (throughout year)	Various Employees		904.25
IL Health Care Association Annual Convention	Melissa Francque	Executive Director	795.00
IL Health Care Association ID/DD Symposium	Melissa Francque	Executive Director	125.00
A Rudolph K. Muzzarelli HFS Driver Safety Training	24 Attendees	Various	1,420.00
A Bethesda Basics of Safe Lifting	Dianne McFadden	Day Training - QMRP	42.54
A Consultancy on International Education General Evaluation	Cesar Augustus Escabillas	Day Training - Assistant	170.00
A DSB Worldwide, Inc. Food Handler Training	5 Attendees	Food Service Dept.	35.00
A Kreider Services Inc. The Out-of-Sync Child: Sensory Processing Disorder"	Debra Buse & Amanda Zook	Day Training - QMRP	220.00
A Northwestern Illinois Center for Independent Living Disabilities Expo	Paula Schelder	Day Training - Program Director	25.00
A Allocated Regional Support Costs			109.60
Line 23 Column 4 Total:			16,373
Line 23 Column 7 Adjustment - Corporate/Home Office Allocated Costs:			484
Line 23 Column 6 Total:			16,857
Unallowable Amounts above removed through SCH 5 Adjustments:			
A Non-care related amounts noted above:			(2,022)
Allocation for non-care-related Education and Day Training (See Pg 11.2 & 5A)			(5,043)
Line 23 Column 8 Total:			9,792
			0

Exceptional Care & Training Center
Schedule V Supplemental Schedule
Reclassifications

DESCRIPTION	INCREASE / (DECREASE)	SCH V LINE.COL
1 Reclassification of C.N.A. Training Expenses for Trainers/Trainees		
C.N.A. Training	87,448	13.5
Nursing & Medical Records	(87,448)	10.5

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.)

	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	(786,889)	43		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(845)	20		18
19	Entertainment				19
20	Contributions	(1,717)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,079)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	881	27		24
25	Fund Raising, Advertising and Promotional	(11,868)	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	(841,268)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,642,785)		\$	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)	(105,990)	19, 34	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (105,990)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,748,775)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Income Offset - Contributions Received	\$ (34,862)	21	1
2	Unallowable Depr Exp (below threshold, non-cap)	(81,129)	30	2
3	Unallowable Lobbying Portion of ILHCA Dues	(1,901)	20	3
4				4
5	Unallowable Portion of Inservice Training/Edu	(2,022)	23	5
6	Unallowable Portion of Travel/Seminar	(256)	24	6
7				7
8				8
9				9
10				10
11				11
12				12
13	Specific GL DT Exp see Pg5 ln 3			13
14	Unallowable Day Trng Alloc - Dietary	(41,862)	1	14
15	Unallowable Day Trng Alloc - Food	(43,732)	2	15
16	Unallowable Day Trng Alloc - Hskpg	(48,073)	3	16
17	Unallowable Day Trng Alloc - Maint	(20,917)	6	17
18	Unallowable Day Trng Alloc - Nursing	(233,045)	10	18
19	Unallowable Day Trng Alloc - Therapy	(8,368)	10a	19
20	Unallowable Day Trng Alloc - Soc Svcs	0	12	20
21	Unallowable Day Trng Admin Alloc	(41,716)	17	21
22	Unallowable Day Trng Dir Fees	(21,245)	18	22
23	Unallowable Day Trng Prof Svcs Alloc	(71,465)	19	23
24	Unallowable Day Trng Dues/Fees Alloc	(16,988)	20	24
25	Unallowable Day Trng Clerical Alloc	(31,752)	21	25
26	Unallowable Day Trng EE Ben Alloc	(113,873)	22	26
27	Unallowable Day Trng Insrvt/Trn Alloc	(5,043)	23	27
28	Unallowable Day Trng Travel/Seminar Alloc	(836)	24	28
29	Unallowable Day Trng Insur Alloc	(9,850)	26	29
30	Unallowable Day Trng Rent Equip Alloc	(1,658)	35	30
31	Unallowable Day Trng Transport Alloc	(10,675)	39	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	(841,268)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Exceptional C & Training Ctr# 0035477

Report Period Beginning:

07/01/2015

Ending:

06/30/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(41,862)	0	0	0	0	0	0	0	0	0	0	(41,862)	1
2	Food Purchase	(43,732)	0	0	0	0	0	0	0	0	0	0	(43,732)	2
3	Housekeeping	(48,073)	0	0	0	0	0	0	0	0	0	0	(48,073)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,824	0	0	0	0	0	0	0	0	1,824	5
6	Maintenance	(20,917)	0	120	0	0	0	0	0	0	0	0	(20,797)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(154,584)	0	1,944	0	0	0	0	0	0	0	0	(152,640)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(233,045)	0	0	0	0	0	0	0	0	0	0	(233,045)	10
10a	Therapy	(8,368)	0	0	0	0	0	0	0	0	0	0	(8,368)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(241,413)	0	0	0	0	0	0	0	0	0	0	(241,413)	16
	C. General Administration													
17	Administrative	(41,716)	0	114,753	0	0	0	0	0	0	0	0	73,037	17
18	Directors Fees	(21,245)	0	0	0	0	0	0	0	0	0	0	(21,245)	18
19	Professional Services	(72,544)	0	(311,807)	10,500	0	0	0	0	0	0	0	(373,851)	19
20	Fees, Subscriptions & Promotions	(33,319)	0	789	0	0	0	0	0	0	0	0	(32,530)	20
21	Clerical & General Office Expenses	(66,614)	0	3,694	0	0	0	0	0	0	0	0	(62,920)	21
22	Employee Benefits & Payroll Taxes	(113,873)	0	19,572	0	0	0	0	0	0	0	0	(94,301)	22
23	Inservice Training & Education	(7,065)	0	484	0	0	0	0	0	0	0	0	(6,581)	23
24	Travel and Seminar	(1,092)	0	17,192	0	0	0	0	0	0	0	0	16,100	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(9,850)	0	1,919	29,668	0	0	0	0	0	0	0	21,737	26
27	Other (specify):*	881	0	0	0	0	0	0	0	0	0	0	881	27
28	TOTAL General Administration	(366,437)	0	(153,404)	40,168	0	0	0	0	0	0	0	(479,673)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(762,434)	0	(151,460)	40,168	0	0	0	0	0	0	0	(873,726)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Exceptional C & Training Ctr # 0035477 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(81,129)	0	2,547	286,376	0	0	0	0	0	0	0	207,794	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	163,941	0	0	0	0	0	0	0	163,941	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	5,645	(484,554)	0	0	0	0	0	0	0	(478,909)	34
35	Rent-Equipment & Vehicles	(1,658)	0	323	0	0	0	0	0	0	0	0	(1,335)	35
36	Other (specify):*	0	0	0	31,024	0	0	0	0	0	0	0	31,024	36
37	TOTAL Ownership	(82,787)	0	8,515	(3,213)	0	0	0	0	0	0	0	(77,485)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(10,675)	0	0	0	0	0	0	0	0	0	0	(10,675)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(786,889)	0	0	0	0	0	0	0	0	0	0	(786,889)	43
44	TOTAL Special Cost Centers	(797,564)	0	0	0	0	0	0	0	0	0	0	(797,564)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,642,785)	0	(142,945)	36,955	0	0	0	0	0	0	0	(1,748,775)	45

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>Walter Lawson Children's Home</u>	<u>Loves Park, IL</u>	<u>Medical Rehabilitation</u>	<u>Lexington, KY</u>	<u>Mgmt Co.</u>
		<u>Swann Special Care Center</u>	<u>Champaign, IL</u>	<u>Hoosier Care Investme</u>	<u>Nashville, TN</u>	<u>NFP Affiliated Co.</u>
		<u>Exceptional Living of Brazil</u>	<u>Brazil, IN</u>	<u>Sterling Facility Comp</u>	<u>Sterling, IL</u>	<u>Property Co.</u>
		<u>Richland-Bean Blossom Health Care</u>	<u>Ellettsville, IN</u>			
		<u>Vernon Manor Children's Home</u>	<u>Wabash, IN</u>			
		<u>Randolph Nursing Home</u>	<u>Winchester, IN</u>			
		<u>Claremont Center</u>	<u>Point Pleasant, NJ</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	18	<u>Group Mgmt/Dir Fees</u>	<u>\$ 78,864</u>	<u>Hoosier Care, Inc.</u>	<u>100.00%</u>	<u>\$ 78,864</u>	<u>\$</u>	<u>1</u>
2	V				<u>Note: See Schedule VII Section C for description</u>				<u>2</u>
3	V								<u>3</u>
4	V								<u>4</u>
5	V								<u>5</u>
6	V		<u>PLEASE SEE CONTINUED DISCLOSURE AND DETAIL OF ADJUSTMENTS ON THE NEXT PAGE (6A):</u>						<u>6</u>
7	V								<u>7</u>
8	V								<u>8</u>
9	V								<u>9</u>
10	V								<u>10</u>
11	V								<u>11</u>
12	V								<u>12</u>
13	V								<u>13</u>
14	Total			<u>\$ 78,864</u>			<u>\$ 78,864</u>	<u>\$ *</u>	<u>14</u>

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

Facility Name & ID Number

Exceptional C & Training Ctr

0035477

Report Period Beginning:

07/01/2015

Ending:

06/30/2016

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Churchman Village	Newark, DE				1
2			Harbor Health Care	Lewes, DE				2
3			Parkview Nursing	Wilmington, DE				3
4			Clearwater Care Center	Eau Claire, WI				4
5			Bethel Center	Arpin, WI				5
6			Colonial Center	Colby, WI				6
7			Karmenta Center	Madison, WI				7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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		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)	
15	V	19	Rel. Party Management Fee	\$ 323,725	Medical Rehabilitation Centers, LLC	37.50%	\$	\$ (323,725)	15
16	V				dba Exceptional Living Centers				16
17	V				Hoosier Care owns a beneficial interest in MRC				17
18	V				Note: Please see Schedule VIII for detail of Col. 7 amts				18
19	V	5	Utilities				1,824	1,824	19
20	V	6	Maintenance				120	120	20
21	V	17	Administrative				114,753	114,753	21
22	V	19	Professional Services				11,918	11,918	22
23	V	20	Dues, Fees, Subscriptions				789	789	23
24	V	21	Clerical & General Office				3,694	3,694	24
25	V	22	Employee Benefits & Payroll Taxes				19,572	19,572	25
26	V	23	Inservice Training & Education				484	484	26
27	V	24	Travel & Seminar				17,192	17,192	27
28	V	26	Insurance				1,919	1,919	28
29	V	30	Depreciation				2,547	2,547	29
30	V	34	Rent - Facility & Grounds				5,645	5,645	30
31	V	35	Rent - Equipment				323	323	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V		PLEASE SEE CONTINUED DISCLOSURE AND DETAIL OF ADJUSTMENTS ON THE NEXT PAGE (6B):						37
38	V								38
39	Total			\$ 323,725			\$ 180,780	\$ * (142,945)	39

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

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. ☒ 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)	
15	V	34	Rel. Party Bldg/Equip Rent	\$ 484,554	Sterling Facility Company, LLC	100.00%	\$	\$ (484,554)	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		286,376	286,376	21
22	V	32	Actual Interest (net) of Rel Pty		-Interest (net of interest income)		157,480	157,480	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		29,668	29,668	24
25	V	36	Actual Mortgage Ins of Rel Pty		-Mortgage Insurance		31,024	31,024	25
26	V	19	Actual Accting Fees of Rel Pty		-Accounting Fees		10,500	10,500	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			\$ 484,554			\$ 521,509	\$ * 36,955	39

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

Facility Name & ID Number Exceptional C & Training Ctr # 0035477 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	Douglass Smith	Board Member	Governance	0%						5
6	Stephen Wood	Board Member	Governance	0%						6
7	NOTE: Fees are paid by ECTC to Hoosier Care Investments, LLC ("HCI"; an affiliated not-for-profit) which go toward fees for members of the Boards of Directors									7
8	of HCI affiliated facilities, Exceptional Care & Training Center being one of many. Therefore no Board Fees or compensation paid directly by ECTC to the									8
9	Directors, but rather the fees paid by ECTC to HCI are combined with similar fees paid by other facilities, for HCI to provide governance and managerial oversight,									9
10	including payment by HCI to Board members of each legal entity. Fees paid by other IL facilities are shown on Page 7.1.									10
11	The entire amount of fees included on this report, grouped on Line 18, is disclosed here at actual cost to the facility:									11
12								ADMIN FEES	78,864	18.8
13								TOTAL	\$ 78,864	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 Directors/Administration Fees by other Nursing Homes

Walter Lawson Children's Home	92,940
Swann Special Care Center	115,475
Exceptional Care & Training Center	78,864

Facility Name & ID Number	Exceptional C & Training Ctr
---------------------------	------------------------------

0035477

Report Period Beginning:

07/01/2015

Ending: 6/30/2016

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, dba Except

Street Address

1050 Chinoe Road, Suite 350

City / State / Zip Code

Lexington, KY 40502

Phone Number

(859) 255-0075

Fax Number

(859) 281-5150

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	5	Utilities	Direct Cost	20	\$ 180,779	\$	2,145	\$ 1,824	1
2	6	Maintenance	Direct Cost	20	180,779		141	120	2
3	17	Administrative	Direct Cost	20	180,779		134,979	114,753	3
4	19	Professional Services	Direct Cost	20	180,779		14,019	11,918	4
5	20	Dues, Fees, Subscriptions	Direct Cost	20	180,779		928	789	5
6	21	Clerical & General Office	Direct Cost	20	180,779		4,345	3,694	6
7	22	Employee Benefits & Payroll Taxes	Direct Cost	20	180,779		23,021	19,571	7
8	23	Inservice Training & Education	Direct Cost	20	180,779		569	484	8
9	24	Travel & Seminar	Direct Cost	20	180,779		20,222	17,192	9
10	26	Insurance	Direct Cost	20	180,779		2,257	1,919	10
11	30	Depreciation	Direct Cost	20	180,779		2,996	2,547	11
12	32	Interest	Direct Cost	20	180,779		0	0	12
13	34	Rent - Facility & Grounds	Direct Cost	20	180,779		6,639	5,644	13
14	35	Rent - Equipment	Direct Cost	20	180,779		380	323	14
15									15
16									16
17		Please see attached allocation workpaper							17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 2,530,906	\$		\$ 180,778	25

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 Financing		11/1/12	\$ 6,675,000	\$ 6,131,626	11/1/42	0.0254	\$ 157,617	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	GE Healthcare Finance		X	Working Capital	\$0.00	06/24/14	5,750,000	\$0.00	10/27/19	Variable	\$0.00	6	
7												7	
8												8	
9	TOTAL Facility Related				\$0.00		\$ 12,425,000	\$ 6,131,626			\$ 157,617	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 12,425,000	\$ 6,131,626			\$ 157,617	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 31,024 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.)

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 2015 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 2016 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:		2011		8	
		2012		9	
		2013		10	
		2014		11	
		2015		12	
Note: This facility became exempt from Property Taxes starting on 1/1/1996.					
				13	FOR BHF USE ONLY
		FROM R. E. TAX STATEMENT FOR 2015 \$		13	
		PLUS APPEAL COST FROM LINE 5 \$		14	
		LESS REFUND FROM LINE 6 \$		15	
		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.

FACILITY NAME Exceptional C & Training Ctr COUNTY Whiteside
FACILITY IDPH LICENSE NUMBER 0035477
CONTACT PERSON REGARDING THIS REPORT _____
TELEPHONE () _____ FAX #: () _____

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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.)

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).

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 detail.

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

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

(E) Exceptional Care & Training Center operates a Developmental Day Training program in dedicated space offsite from the skilled nursing facility. All costs specifically attributable to this program in dedicated GL accounts, including wages/salaries, supplies, rent and occupancy costs, have been grouped in line 43 of Schedule V, "Other Cost 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. Allocation bases utilizing program statistics (direct labor hours, program hours of operation, square footage, etc) are applied to shared costs to determine the portion to be disallowed via adjustments on Schedule VI.

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

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	\$	\$ 1,865,166	4
5	15			1991	358,311	11,944	30	11,944		299,150	5
6	5			2004							6
7											7
8											8
	Improvement Type**										
9	Nurses Station Remodel			8/15/2013	19,747.00	1,974.70	10	1,975		5,759.54	9
10	Nurses Station Remodel			10/2/2013	19,748.00	1,974.80	10	1,975		5,430.70	10
11	Replaced Fire Door			10/3/2013	5,615.00	561.50	10	562		1,544.13	11
12	New Dumbwaiter			12/20/2013	10,898.00	1,089.80	10	1,090		2,724.50	12
13	Installation of dumbwaiter			4/10/2014	21,797.00	2,179.70	10	2,180		4,904.33	13
14	New Tile			6/12/2014	2,578.41	257.84	10	258		537.17	14
15	Emergency Generator			7/31/2014	10,775.00	1,077.50	10	1,078		2,065.21	15
16	Emergency Generator			7/31/2014	10,775.00	1,077.50	10	1,078		2,065.21	16
17	Emergency Generator			7/31/2014	12,810.00	1,281.00	10	1,281		2,455.25	17
18	New Roof			12/30/2014	5,950.00	595.00	10	595		879.51	18
19	New Roof			12/30/2014	7,350.00	735.00	10	735		1,102.50	19
20	New Roof			12/30/2014	6,000.00	600.00	10	600		900.00	20
21	Replace Dry Wall in 3 Rooms			11/7/2014	2,950.00	295.00	10	295		491.67	21
22	New Metal Doors			11/19/2014	5,635.00	563.50	10	564		892.21	22
23	3 Bathroom Remodels			12/10/2014	4,185.00	418.50	10	419		662.63	23
24	Replaced Drain Line in Kitch			11/19/2014	2,700.04	270.00	10	270		427.50	24
25	Installed FRP Board in Sever			3/19/2015	3,010.00	301.00	10	301		376.25	25
26	Bedroom/Bath Remodel			5/20/2015	60,000.00	6,000.00	10	6,000		6,500.00	26
27	Bedroom/Bath Remodel			11/19/2015	40,000.00	2,333.33	10	2,333		2,333.33	27
28	Bedroom/Bath Remodel			1/16/2016	28,040.28	1,168.35	10	1,168		1,168.35	28
29	Q Office & Conf Room Repairs			10/8/2015	3,340.81	250.56	10	251		250.56	29
30	Repairs to double fire doors			4/1/2016	2,752.44	68.81	10	69		68.81	30
31	REPLACE WATER UNIT			6/27/1991	8,780.00	-	10			8,780.00	31
32	REPLACE HEAT EXCHANGER-SC			2/3/1992	4,061.99	-	10			4,061.99	32
33	BOILER TUBES - SCHMIDT PL			3/4/1992	7,146.73	-	10			7,146.73	33
34	ROOF - HAUS BLDRS			3/19/1992	11,117.91	-	10			11,117.91	34
35	KITCHEN TILE SCHMIDT & AS			4/20/1992	3,660.10	-	10			3,660.10	35
36	HEATING & COOLING UNIT SC			6/29/1992	7,757.00	-	10			7,757.00	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 C & Training Ctr

0035477

Report Period Beginning:

07/01/2015 Ending: 06/30/2016

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

1	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 LIGHT FIXTURES	7/1/1992	\$ 3,743.09	\$ -	10	\$	\$	\$ 3,743.09	37
38 ELECTRICAL WORK	4/23/1993	3,255.48	-	10			3,255.48	38
39 TILE FOR FLOORS IN TUB RO	2/16/1995	4,405.00	-	10			4,405.00	39
40 THERMOCOUPLE ON BOILER	3/8/1995	2,550.17	-	10			2,550.17	40
41 REPLACE FIRE ALARM	6/30/1995	3,743.32	-	10			3,743.32	41
42 PART:GENERATOR,TRANSFER S	9/11/1998	2,746.49	-	10			2,746.49	42
43 INSTALL TILE:WALLS,STAIRC	12/2/1998	4,495.00	-	10			4,495.00	43
44 2 HOT WATER TANKS	3/5/1999	7,119.35	-	10			7,119.35	44
45 COOLING SYSTEM-LAUNDRY/KI	1/22/2000	4,650.00	232.50	20	233		3,836.46	45
46 NEW TILE IN DINING RM/CLA	4/11/2000	4,770.00	-	15			4,770.00	46
47 FURNISH & INSTALL AWNING.	4/6/2001	2,771.26	138.46	15	138		2,771.26	47
48 LABOR & MAT-BREAKER PANEL	4/12/2001	3,930.00	196.59	15	197		3,930.00	48
49 INSTALL WATER HEATER	7/5/2001	3,341.20	222.76	15	223		3,341.20	49
50 INTERNET SET-UP-WIRING CA	2/21/2002	3,060.62	204.04	15	204		2,941.52	50
51 STORM WINDOW PROJECT	6/24/2002	8,937.00	446.85	20	447		6,293.17	51
52 New Electrical System (Mulit	9/9/2004	6,637.40	-	7			6,637.40	52
53 34 heat/smoke detectors	12/2/2004	2,800.00	-	7			2,800.00	53
54 replace compressor in lobby	8/9/2005	11,445.00	763.00	15	763		8,329.42	54
55 Sprinkler system-Phase I	6/30/2006	33,165.00	2,211.00	15	2,211		22,110.00	55
56 Water heater	6/16/2006	4,716.60	471.66	10	472		4,716.60	56
57 Sprinkler system-Phase II	6/30/2006	7,920.00	528.00	15	528		5,280.00	57
58 Sprinkler system-Phase III	9/21/2006	13,365.00	891.00	15	891		8,687.25	58
59 Light fixtures (24) and new	1/22/2007	6,433.74	428.92	15	429		4,039.00	59
60 Ductwork & roof exhaust for	3/15/2007	3,497.88	233.19	15	233		2,176.44	60
61 Brake assembly on dumbwaiter	7/24/2007	4,389.00	292.60	15	293		2,609.02	61
62 Tile walls in classrooms 1-4	1/22/2008	9,300.00	620.00	15	620		5,218.33	62
63 Privacy wall in day rooms (2	6/6/2008	3,297.37	219.82	15	220		1,776.88	63
64 Wiring & outlets for kitchen	9/26/2008	3,434.00	228.93	15	229		1,774.21	64
65 Exit & boiler room doors rep	12/18/2008	2,711.50	180.77	15	181		1,355.77	65
66 Avaya phone system for day t	5/21/2009	7,010.00	701.00	10	701		4,965.42	66
67 5 ton rooftop hvac unit	7/9/2009	6,485.00	432.33	15	432		3,026.31	67
68 26 x 12 storage shed	7/12/2009	8,280.00	552.00	15	552		3,864.00	68
69 Water heaters (2)	8/13/2009	11,250.00	1,125.00	10	1,125		7,781.25	69
70 TOTAL (lines 4 thru 69)		\$ 3,231,147	\$ 106,338		\$ 106,338	\$	\$ 2,407,468	70

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

Facility Name & ID Number Exceptional C & Training Ctr

0035477

Report Period Beginning:

07/01/2015 Ending: 06/30/2016

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 12A, Carried Forward		\$ 3,231,147	\$ 106,338		\$ 106,338	\$	\$ 2,407,468	1
2	Roof for courtyard pavillion	5/28/2010	6,657.00	443.80	15	444		2,699.78	2
3	Grease trap replaced and ele	5/20/2010	7,217.12	481.14	15	481		2,926.94	3
4	Misc electrical work	10/6/2010	4,915.00	327.67	15	328		1,884.10	4
5	Main drain line replaced	10/9/2010	2,818.05	187.87	15	188		1,080.25	5
6	Parapet wall on roof	10/28/2010	8,215.00	410.75	20	411		2,327.58	6
7	Tile work for walls in south	7/15/2010	11,593.55	1,159.36	10	1,159		6,956.16	7
8	Remodel restroom for isolati	2/28/2011	2,556.18	255.62	10	256		1,363.31	8
9	Tile in lobby and surroundin	6/14/2011	3,274.25	327.43	10	327		1,664.44	9
10	Roof hvac units (2)	10/3/2011	8,173.00	817.30	10	817		3,882.18	10
11	Water heater for south wing	10/4/2011	7,936.94	793.69	10	794		3,770.03	11
12	Replace header on basement d	12/7/2011	4,870.21	324.68	15	325		1,488.12	12
13	Medical room remodel	12/1/2012	8,081.62	808.16	10	808		2,895.91	13
14	Bryant a/c units (2) and dis	4/12/2013	13,875.00	925.00	15	925		3,006.25	14
15	Boiler	3/1/2013	22,524.83	1,501.66	15	1,502		5,005.53	15
16	Boiler Repair/Replacement	7/23/2013	29,683.28	2,968.33	10	2,968		8,657.63	16
17	Repave Parking Lot	11/1/2013	49,636.23	4,963.62	10	4,964		13,236.32	17
18	Repave Parking Lot	11/1/2013	54,183.00	5,418.30	10	5,418		14,448.80	18
19	Concrete Dumpster Pad	10/8/2014	8,970.00	897.00	10	897		1,569.75	19
20	GATE & FENCE SCARS	5/29/1992	4,038.00	-	10			4,038.00	20
21	NEW WATER MAIN	10/11/1993	12,203.63	-	10			12,203.63	21
22	RESEAL PARKING AREA	6/7/1997	2,845.00	-	10			2,845.00	22
23	TANK REPLACEMENT - PIPECO	9/28/1998	9,890.00	494.50	20	495		8,818.68	23
24	EXCAVATION OF NEW PARKING	5/11/2001	12,415.00	620.75	20	621		9,414.73	24
25	WALKWAY	8/28/2001	4,119.05	274.60	15	275		4,096.04	25
26	PRIVACY FENCE	6/20/2002	2,550.00	-	10			2,550.00	26
27	Parking Lot Renovation	9/11/2004	3,499.00	-	10			3,499.00	27
28	Portions of parking lot repl	10/20/2008	3,670.00	367.00	10	367		2,813.67	28
29	Concrete sidewalk for emerge	7/26/2009	7,119.00	474.60	15	475		3,282.65	29
30	Trex security fence	9/28/2009	9,142.00	609.47	15	609		4,113.92	30
31	Greenhouse for therapy use	12/22/2010	12,474.83	1,247.48	10	1,247		6,861.14	31
32	Rentention pond	6/6/2011	7,273.10	727.31	10	727		3,697.16	32
33	Vinyl coated chain link fenc	6/7/2011	6,475.00	647.50	10	648		3,291.46	33
34	TOTAL (lines 1 thru 33)		\$ 3,584,041	\$ 134,812		\$ 134,812	\$	\$ 2,557,856	34

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

Facility Name & ID Number Exceptional C & Training Ctr

0035477

Report Period Beginning:

07/01/2015 Ending: 06/30/2016

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,584,041	\$ 134,812		\$ 134,812	\$	\$ 2,557,856	1
2	Hardscape & landscape for re	6/6/2011	3,936.00	393.60	10	394		2,000.80	2
3	Replace sidewalks	9/20/2011	6,617.00	661.70	10	662		3,143.08	3
4	INSTALL NEW SEWER LINES	7/14/1993	4,104.82	-	10			4,104.82	4
5	REPLACE PARTS ON 2 SUMP P	5/24/1994	4,033.53	-	10			4,033.53	5
6	Sewage pump	2/7/2009	4,132.90	413.29	10	413		3,065.23	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,606,865	\$ 136,281		\$ 136,281	\$	\$ 2,574,204	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	\$ 267,867	\$ 46,483	\$ 46,483	\$	3-10	\$ 143,352	71
72	Current Year Purchases	105,092	7,878	7,878		5-7	7,878	72
73	Fully Depreciated Assets	599,064	10,478	10,478		3-10	599,064	73
74	Depr Exp (Net Allowable) - Rel Pty Alloc Sch VIII		2,547	2,547				74
75	TOTALS	\$ 972,023	\$ 67,386	\$ 67,386	\$		\$ 750,294	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	\$ 19,946
77									
78									
79									
80	TOTALS			\$ 41,267	\$ 4,127	\$ 4,127	\$		\$ 19,946

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)			\$ 5,034,240
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 207,794
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 207,794
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 3,344,444

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86	Vehicle in Excess of 1 Allowed	\$ 244,123	\$ 31,436	\$ 155,934
87	Assets below IL Capital Threshold/Other	565,604	31,842	456,503
88	Assets Disallowed by HFS Cap Review	533,727	17,851	277,978
89				
90				
91	TOTALS	\$ 1,343,454	\$ 81,129	\$ 890,415

G. Construction-in-Progress		
	Description	Cost
92	Hardware, Wall/Door Panels	\$ 15,000
93	Hallway Handrails	5,000
94		
95		\$ 20,000

* 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: 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		5,645	10	10	5
6								6
7	TOTAL				\$ 5,645			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: _____*

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

15. Is Movable equipment rental included in building rental?

☒ X YES ☐ NO

16. Rental Amount for movable equipment: \$ 6,593 Description: Copiers/Scanners - Canon Financial Solutions, Inc: \$5,121; Postage Meter - Pitney Bowes: \$1,149; Corp All
(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 01/01/2011

Ending 01/01/2021

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

Fiscal Year Ending Annual Rent

12. 6/30/2017 \$ Home Office Alloc Amt

13. 6/30/2018 \$ Home Office Alloc Amt

14. 6/30/2019 \$ Home Office Alloc Amt

* 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.

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	138	1,522		1,660
3	Classroom Wages (a)		28,270		28,270
4	Clinical Wages (b)		45,232		45,232
5	In-House Trainer Wages (c)	1,024	11,262		12,286
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 1,162	\$ 86,286	\$	\$ 87,448
10	SUM OF line 9, col. 1 and 2 (e)	\$ 87,448			

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	55
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	5
2. From other facilities (f)	
TOTAL TRAINED	60

(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	10a.3	hrs		82	8,200		82	8,200	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.1	240 hrs	16,777				240	16,777	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		37	2,421		37	2,421	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	39.3	hrs			8,009			8,009	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			\$ 16,777	119	\$ 18,630	\$	359	\$ 35,407	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 500	\$ 1,100	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 801)	656,747	656,747	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(15,554)	9,302	6
7	Other Prepaid Expenses	11,088	11,088	7
8	Accounts Receivable (owners or related parties)	18,140,909	18,140,909	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 18,793,690	\$ 18,819,146	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		414,085	13
14	Buildings, at Historical Cost		4,322,075	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		1,641,252	16
17	Accumulated Depreciation (book methods)		(4,234,915)	17
18	Deferred Charges		170,274	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		140,541	21
22	Other Long-Term Assets (spe CIP		20,284	22
23	Other(specify): <u>Goodwill</u>	396,154	396,154	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 396,154	\$ 2,869,750	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 19,189,844	\$ 21,688,896	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 144,779	\$ 144,779	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		164,321	29
30	Accrued Salaries Payable	293,086	293,086	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,421	20,421	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		12,979	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Rel Party Lessor</u>		475,236	36
37	<u>Rounding</u>	2	1	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 458,288	\$ 1,110,823	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,967,305	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)	\$	\$ 5,967,305	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 458,288	\$ 7,078,128	46
47	TOTAL EQUITY(page 18, line 24)	\$ 18,731,556	\$ 14,610,768	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 19,189,844	\$ 21,688,896	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 18,013,636	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 18,013,636	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	717,920	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)	\$ 717,920	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 18,731,556	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Exceptional C & Training Ctr

0035477

Report Period Beginning: 07/01/2015

Ending: 06/30/2016

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,207,219	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,207,219	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	96,845	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)	\$ 96,845	23
	D. Non-Operating Revenue		
24	Contributions	34,862	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 34,862	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Developmental Day Training, Misc. Income	1,573,602	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,573,602	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,912,528	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	883,262	31
32	Health Care	2,222,341	32
33	General Administration	1,459,702	33
	B. Capital Expense		
34	Ownership	495,569	34
	C. Ancillary Expense		
35	Special Cost Centers	817,029	35
36	Provider Participation Fee	316,705	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,194,608	40
41	Income before Income Taxes (line 30 minus line 40)**	717,920	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 717,920	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 5,205,391	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Hospice</u>	1,828	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,207,219	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.

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	1,924	2,117	\$ 93,702	\$ 44.26	1
2	Assistant Director of Nursing	1,825	2,049	67,105	32.75	2
3	Registered Nurses	3,353	3,629	89,528	24.67	3
4	Licensed Practical Nurses	19,934	22,042	505,413	22.93	4
5	CNAs & Orderlies	72,720	78,567	972,224	12.37	5
6	CNA Trainees					6
7	Licensed Therapist	224	240	16,777	69.90	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,879	2,119	46,579	21.98	9
10	Activity Assistants	16,556	18,104	200,050	11.05	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,971	2,116	40,328	19.06	13
14	Head Cook	5,856	6,216	68,693	11.05	14
15	Cook Helpers/Assistants	5,309	5,755	52,389	9.10	15
16	Dishwashers					16
17	Maintenance Workers	1,901	2,095	43,108	20.58	17
18	Housekeepers	12,482	13,622	164,694	12.09	18
19	Laundry	10,931	11,833	144,018	12.17	19
20	Administrator	2,031	2,203	135,449	61.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,001	4,213	72,965	17.32	24
25	Vocational Instruction	45,122	49,182	656,588	13.35	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	1,896	2,105	52,792	25.08	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	209,915	228,207	\$ 3,422,402 *	\$ 15.00	34

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	97	\$ 5,388	3.1	35
36	Medical Director	N/A	21,000	3.9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	*Note: Medical Director paid flat fee, not hourly				47
48					48
49	TOTAL (lines 35 - 48)	97	\$ 26,388		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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Melissa Franque	Administrator	0	\$ 135,449
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 135,449
B. Administrative - Other			
Description			Amount
			\$ 0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
Medical Rehab (dba Ex Living Ctrs)	Management Services	\$	380,784
ADP / Paycor	Payroll Processing		17,231
Various	Accounting/audit services		15,590
Various (see 21.1 for detail)	Legal services		10,571
Ashley Rountree & Assoc.	Feasibility study		3,000
SBM, Post Time Prod., Misc	Document management		786
VCPI	Information tech services		3,972
See Pg 6 for Mgmt Svc Adj			
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 431,934
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	49,651
Unemployment Compensation Insurance			27,318
FICA Taxes			190,034
Employee Health Insurance			273,393
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Retirement Plan			6,567
Group Allocation - Pg 8			19,571
Less Pg5A Adj for Unallowable DT/EDU			(113,873)
TOTAL (agree to Schedule V, line 22, col.8)			\$ 452,661
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			7,864
Health Care Worker Background Check (Indicate # of checks performed 70)			2,352
Public Rel/Mkting/Fundraising			11,868
Bank Fees			44,146
Other Dues, Fees, Subs			9,726
Group Allocation - Pg8			789
Less Pg5A Adj for Unallowable DT/EDU			(16,988)
Less other Unallowable Items (5-5A)			(16,331)
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 43,426
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
N/A			
In-State Travel			
See Page 21.2 for Detail			5,576
Pg 5 Adj - Unallowable Items			(256)
Corporate/Group Travel Alloc - G&A			17,192
Seminar Expense			
Less Unallowable Day Training Alloc			(836)
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	21,676

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number

Exceptional C & Training Ctr

0035477

Report Period Beginning: 07/01/2015

Ending: 06/30/2016

Exceptional C & Training Ctr

Schedule XIX Supplemental Schedule

Legal Fees Detail

DATE	DESCRIPTION	Amount
1 Legal Fees detail for SCH XIX-C		
8/7/2015	Miller, Lancaster, & Walker, P.C.	\$ 654.00
8/19/2015	Baker, Donelson, Bearman, Caldwell & Berkowitz	\$ 173.33
9/22/2015	Baker, Donelson, Bearman, Caldwell & Berkowitz	\$ 796.49
9/22/2015	Baker, Donelson, Bearman, Caldwell & Berkowitz	\$ 87.50
12/14/2015	SmithAmundsen	\$ 675.00
12/14/2015	Duane Morris LLP	\$ 22.66
2/5/2016	Baker, Donelson, Bearman, Caldwell & Berkowitz	\$ 160.00
2/29/2016	Baker, Donelson, Bearman, Caldwell & Berkowitz	\$ 387.17
2/29/2016	Baker, Donelson, Bearman, Caldwell & Berkowitz	\$ 195.34
2/29/2016	Baker, Donelson, Bearman, Caldwell & Berkowitz	\$ 155.41
7/14/2015	Stites&Harbison PLLC	\$ 22.00
10/19/2015	Stites&Harbison PLLC	\$ 3.12
10/19/2015	Stites&Harbison PLLC	\$ 4.68
5/17/2016	Stites&Harbison PLLC	\$ 41.56
7/31/2015	In House Counsel Legal Fees	\$ 522.88
8/31/2015	In House Counsel Legal Fees	\$ 576.14
9/30/2015	In House Counsel Legal Fees	\$ 505.07
10/31/2015	In House Counsel Legal Fees	\$ 506.44
11/30/2015	In House Counsel Legal Fees	\$ 535.05
12/31/2015	In House Counsel Legal Fees	\$ 480.04
1/31/2016	In House Counsel Legal Fees	\$ (51.36)
1/31/2016	In House Counsel Legal Fees	\$ 724.75
2/29/2016	In House Counsel Legal Fees	\$ 689.96
3/31/2016	In House Counsel Legal Fees	\$ 719.78
4/30/2016	In House Counsel Legal Fees	\$ 626.57
5/31/2016	In House Counsel Legal Fees	\$ 683.83
6/30/2016	In House Counsel Legal Fees	\$ 673.09
		\$ 10,570.50

See Schedule VI for adjustment for unallowable portion.

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

DESCRIPTION	Amount	SCH V LINE.COL
1 In-State Travel Detail		
Amanda Zook, Day Training, in-state travel	78 A	24.3
Barbara Rascoe, Environmental Serv, in-state travel	52 A	24.3
Debbie Bieneman, Housekeeping, in-state travel	68 A	24.3
Gwen Justice, DON, care-related in-state travel	187	24.3
Linda Hartz, Physical Therapist, care-related in-state travel	97	24.3
Melissa Franque, Exec Director, care-related in-state travel	4,558	24.3
Patrick Russo, transport of labs, care-relate in-state travel	59	24.3
Paula Schedler, Day Training	57 A	24.3
Wynell Eakle, Bus Office, care-related out of-state travel	104	24.3
Corporate/Group travel allocation of operations personnel	315	24.3
Other non-care related	-	24.3
	5,576	
1 Out-of-State Travel (All to Home Office related training) Detail		
n/a	-	
	-	
Line 24 Column 4 Total:	5,576	0
Line 24 Column 7 Adjustment - Corporate/Home Office Allocated Costs:	17,192	
Unallowable Amounts above removed through SCH 5 Adjustments:		
A Non-care related amounts noted above:	(256)	
Allocation for non-care-related Education and Day Training	(836)	
(See Pg 11.2 & 5A)		
Line 24 Column 8 Total:	21,676	0

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?
If YES, give association name and amount.

Yes
ILHCA, \$3,199 net after Schedule VI Adj
- (3)

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

No
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
- (5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
6 Years
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 63,149 Line 10
- (7)

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

Yes
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
- (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.
This amount is to be recorded on line 42 of Schedule V.

\$ 316,705
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

- (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?
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.

No
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$ 0
No Indicate the amount. \$
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

Yes
\$ 0
- (17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

Yes
Crowe Horwath
- (18)

Have all costs which do not relate to the provision of long term care been adjusted 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.
Attach invoices and a summary of services for all architect and appraisal fees

Yes