

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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 Cr Training Ctr</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2019</u> to <u>6/30/2020</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) 626-5822</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Douglass Smith</u></td></tr><tr><td>(Title) <u>President</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name <u>Rick Mittman</u> and Title) <u>Managing Director</u></td></tr><tr><td>(Firm Name <u>BKD, LLP</u> & Address) <u>201 N. Illinois St. Suite 700 Indianapolis, IN 46244</u></td></tr><tr><td>(Telephone) <u>(317) 383-4000</u> Fax # <u>(317) 383-4200</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Douglass Smith</u>	(Title) <u>President</u>	(Signed) _____	Paid Preparer	(Date) _____	(Print Name <u>Rick Mittman</u> and Title) <u>Managing Director</u>	(Firm Name <u>BKD, LLP</u> & Address) <u>201 N. Illinois St. Suite 700 Indianapolis, IN 46244</u>	(Telephone) <u>(317) 383-4000</u> Fax # <u>(317) 383-4200</u>												
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	(Type or Print Name) <u>Douglass Smith</u>																								
	(Title) <u>President</u>																								
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	(Telephone) <u>(317) 383-4000</u> Fax # <u>(317) 383-4200</u>																								
Date of Initial License for Current Owners: <u>08/15/1989</u>																									
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501(c)(3)</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></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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	☐ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>Douglass Smith</u> Telephone Number: <u>(615) 647-9004 Ext. 701</u>																									
Email Address: _____																									

Facility Name & ID Number Exceptional Cr Training Ctr

0035477 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	29,523	38		29,561	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,523	38		29,561	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.15%

D. How many bed reserve days during this year were paid by the Department? 72 (Do not include bed reserve 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: 6/30/2020 Fiscal Year: 6/30/2020
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Exceptional Cr Training Ctr # 0035477 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	188,172	9,914	6,471	204,557		204,557	(49,761)	154,796			1
2	Food Purchase		159,950		159,950		159,950	(38,910)	121,040			2
3	Housekeeping	33,040	6,232		39,272		39,272	(10,384)	28,888			3
4	Laundry	147,575	12,241	529	160,345		160,345		160,345			4
5	Heat and Other Utilities			77,653	77,653		77,653	935	78,588			5
6	Maintenance	184,344	28,234	66,267	278,845		278,845	(55,015)	223,830			6
7	Other (specify):*											7
8	TOTAL General Services	553,131	216,571	150,920	920,622		920,622	(153,135)	767,487			8
	B. Health Care and Programs											
9	Medical Director			25,193	25,193		25,193		25,193			9
10	Nursing and Medical Records	2,074,864	180,866	1,843	2,257,573	(69,468)	2,188,105	(292,638)	1,895,467			10
10a	Therapy	11,206	190	2,662	14,058		14,058		14,058			10a
11	Activities	220,551	3,142	124	223,817		223,817	(6,044)	217,773			11
12	Social Services											12
13	CNA Training					69,468	69,468		69,468			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,306,621	184,198	29,822	2,520,641		2,520,641	(298,682)	2,221,959			16
	C. General Administration											
17	Administrative					160,492	160,492	20,239	180,731			17
18	Directors Fees			72,542	72,542		72,542	(18,338)	54,204			18
19	Professional Services			532,023	532,023		532,023	(327,481)	204,542			19
20	Dues, Fees, Subscriptions & Promotions			28,229	28,229		28,229	(18,398)	9,831			20
21	Clerical & General Office Expenses	258,581	12,883	95,292	366,756	(160,492)	206,264	(51,800)	154,464			21
22	Employee Benefits & Payroll Taxes			613,697	613,697		613,697	(115,663)	498,034			22
23	Inservice Training & Education			18,379	18,379		18,379	(5,412)	12,967			23
24	Travel and Seminar			6,001	6,001		6,001	6,731	12,732			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			135,527	135,527		135,527	(342)	135,185			26
27	Other (specify):*											27
28	TOTAL General Administration	258,581	12,883	1,501,690	1,773,154		1,773,154	(510,464)	1,262,690			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,118,333	413,652	1,682,432	5,214,417		5,214,417	(962,281)	4,252,136			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							244,541	244,541			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,748	4,748		4,748	146,530	151,278			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			484,255	484,255		484,255	(478,773)	5,482			34
35	Rent-Equipment & Vehicles			8,160	8,160		8,160	(1,974)	6,186			35
36	Other (specify):*							28,901	28,901			36
37	TOTAL Ownership			497,163	497,163		497,163	(60,775)	436,388			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		12,961	12,594	25,555		25,555	(10,004)	15,551			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			353,544	353,544		353,544		353,544			42
43	Other (specify):* Day Training	755,601	57,597		813,198		813,198	(813,198)				43
44	TOTAL Special Cost Centers	755,601	70,558	366,138	1,192,297		1,192,297	(823,202)	369,095			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,873,934	484,210	2,545,733	6,903,877		6,903,877	(1,846,258)	5,057,619			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	Expense Amount
Relias Learning Core Curriculum Education Software (billed quarterly)	All Employees	Various	16,514
David K. Williams - Food Service Sanitation Certification Course	Various	Cook	375 *
CPR and/or First Aid Cards & Training Material	Various	Various	1,225
Marijuana in the Workplace - What Employers Need to Know	Melissa Franque	Executive Director	40
Employee Handbooks for Illinois Employers	Melissa Franque	Executive Director	100
"New Decade, New Year - Preparing for 2020 and Beyond"	Melissa Franque	Executive Director	125
Line 23 Column 4 Total			18,379
Line 23 Column 7 Adjustment - Corportate/Home Office Allocated Costs:			470
Line 23 Column 6 Total:			18,849
Non-allowable Amounts above removed through Sch 5 Adjustments:			
Non-Care related amounts noted above:			(375) *
Allocation for non-care related education and day training (see Page 11.2 & 5A)			(5,507)
Line 23 Column 8 Total:			12,967
			-

Schedule V Supplemental Schedule Reclassifications		
Description	Increase/Decrease	Sch. V Line.Col
Reclassification of C.N.A Training Expense for Trainers/Trainees		
C.N.A Training	69,468	13.5
Nursing & Medical Records	(69,468)	10.5
Reclassification of Administrator Wages		
Administrative	160,492	17.5
Clerical & General Office Expense	(160,492)	21.5

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	\$ (813,198)	43	\$	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				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	(134)	32		17
18	Fines and Penalties	(1,309)	20		18
19	Entertainment				19
20	Contributions	(450)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(10,034)	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	(917,122)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,742,247)		\$	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	2	
		Amount	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)	(104,011)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (104,011)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,846,258)		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	2	3	4	
		Yes	No	Amount	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	Non-Reimbursable Fees	\$ (428)	21	1
2	Non-Allowable Lobbying Dues	(1,450)	20	2
3	Advertising	(143)	21	3
4	Non-Allowable Depreciation Expense	(64,377)	30	4
5	Non-Allowable Portion of Inservice Training/Edu	(375)	23	5
6	Non-Allowable Portion of Travel/Seminar	(659)	24	6
7	Unallowable Day Trng Alloc - Dietary	(49,761)	1	7
8	Unallowable Day Trng Alloc - Food	(38,910)	2	8
9	Unallowable Day Trng Alloc - Hskpg	(10,384)	3	9
10	Unallowable Day Trng Alloc - Maint	(55,101)	6	10
11	Unallowable Day Trng Alloc - Nursing	(292,638)	10	11
12	Unallowable Day Trng Alloc - Therapy	(6,044)	11	12
13	Unallowable Day Trng Admin Alloc	(48,094)	17	13
14	Unallowable Day Trng Dir Fees	(18,338)	18	14
15	Unallowable Day Trng Prof Svcs Alloc	(89,258)	19	15
16	Unallowable Day Trng Dues/Fees Alloc	(6,757)	20	16
17	Unallowable Day Trng Clerical Alloc	(52,541)	21	17
18	Unallowable Day Trng EE Ben Alloc	(127,199)	22	18
19	Unallowable Day Trng Insrv/Trn Alloc	(5,507)	23	19
20	Unallowable Day Trng Travel/Seminar Alloc	(926)	24	20
21	Unallowable Day Trng Insur Alloc	(35,835)	26	21
22	Unallowable Day Trng Rent Equip Alloc	(2,183)	35	22
23	Unallowable Day Trng Transport Alloc	(10,004)	39	23
24	Flowers	(210)	21	24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(917,122)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Exceptional Cr Training Ctr# 0035477

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

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	(49,761)	0	0	0	0	0	0	0	0	0	0	(49,761)	1
2	Food Purchase	(38,910)	0	0	0	0	0	0	0	0	0	0	(38,910)	2
3	Housekeeping	(10,384)	0	0	0	0	0	0	0	0	0	0	(10,384)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	935	0	0	0	0	0	0	0	0	935	5
6	Maintenance	(55,101)	0	86	0	0	0	0	0	0	0	0	(55,015)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(154,156)	0	1,021	0	0	0	0	0	0	0	0	(153,135)	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	(292,638)	0	0	0	0	0	0	0	0	0	0	(292,638)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(6,044)	0	0	0	0	0	0	0	0	0	0	(6,044)	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	(298,682)	0	0	0	0	0	0	0	0	0	0	(298,682)	16
	C. General Administration													
17	Administrative	(48,094)	0	68,333	0	0	0	0	0	0	0	0	20,239	17
18	Directors Fees	(18,338)	0	0	0	0	0	0	0	0	0	0	(18,338)	18
19	Professional Services	(89,258)	0	(247,570)	9,347	0	0	0	0	0	0	0	(327,481)	19
20	Fees, Subscriptions & Promotions	(19,550)	0	1,152	0	0	0	0	0	0	0	0	(18,398)	20
21	Clerical & General Office Expenses	(53,772)	0	1,972	0	0	0	0	0	0	0	0	(51,800)	21
22	Employee Benefits & Payroll Taxes	(127,199)	0	11,536	0	0	0	0	0	0	0	0	(115,663)	22
23	Inservice Training & Education	(5,882)	0	470	0	0	0	0	0	0	0	0	(5,412)	23
24	Travel and Seminar	(1,585)	0	8,316	0	0	0	0	0	0	0	0	6,731	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(35,835)	0	1,125	34,368	0	0	0	0	0	0	0	(342)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(399,513)	0	(154,666)	43,715	0	0	0	0	0	0	0	(510,464)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(852,351)	0	(153,645)	43,715	0	0	0	0	0	0	0	(962,281)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Exceptional Cr Training Ctr # 0035477 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	(64,377)	0	518	308,400	0	0	0	0	0	0	0	244,541	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(134)	0	0	146,664	0	0	0	0	0	0	0	146,530	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	5,482	(484,255)	0	0	0	0	0	0	0	(478,773)	34
35	Rent-Equipment & Vehicles	(2,183)	0	209	0	0	0	0	0	0	0	0	(1,974)	35
36	Other (specify):*	0	0	0	28,901	0	0	0	0	0	0	0	28,901	36
37	TOTAL Ownership	(66,694)	0	6,209	(290)	0	0	0	0	0	0	0	(60,775)	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	(10,004)	0	0	0	0	0	0	0	0	0	0	(10,004)	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):*	(813,198)	0	0	0	0	0	0	0	0	0	0	(813,198)	43
44	TOTAL Special Cost Centers	(823,202)	0	0	0	0	0	0	0	0	0	0	(823,202)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,742,247)	0	(147,436)	43,425	0	0	0	0	0	0	0	(1,846,258)	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
Hoosier Care, Inc.	100	Walter Lawson Children's Home	Loves Park, IL	Sterling Facility Comp	Sterling, IL	Property Co.
		Swann Special Care Center	Champaign, IL	Hoosier Care Investme	Nashville, TN	NFP Affiliated Co.
		Exceptional Living of Brazil	Brazil, IN	Medical Rehabilitation	Lexington, KY	Mgmt Co.
		Richland Bean-Blossom Healthcare	Ellettsville, IN			
		Vernon Manor Children's Home	Wabash, IN			
		Randolph Nursing Home	Winchester, IN			

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	18	Group Mgmt/Dir Fees	\$ 72,542	Hoosier Care, Inc.	100.00%	\$ 72,542	\$	1
2	V				Note: See Schedule VII Section C for description				2
3	V								3
4	V								4
5	V								5
6	V								6
7	V		PLEASE SEE CONTINUED DISCLOSURE AND DETAIL OF ADJUSTMENTS ON THE NEXT PAGE (6A)						7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 72,542			\$ 72,542	\$ *	14

* 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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		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	\$ 257,754	Medical Rehabilitation Centers, LLC	37.50%	\$	\$ (257,754)	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 Related Party Utilities				935	935	19
20	V	6 Related Party Maintenance				86	86	20
21	V	17 Related Party Administrative				68,333	68,333	21
22	V	19 Related Party Professional Services				10,184	10,184	22
23	V	20 Related Party Dues, Fees, Subscriptions				1,152	1,152	23
24	V	21 Related Party Clerical & General Office				1,972	1,972	24
25	V	22 Related Party Employee Benefits & Payroll Taxes				11,536	11,536	25
26	V	23 Related Party Inservice Training & Education				470	470	26
27	V	24 Related Party Travel & Seminar				8,316	8,316	27
28	V	25 Related Party Other Admin Staff Transportation						28
29	V	26 Related Party Insurance				1,125	1,125	29
30	V	30 Related Party Depreciation				518	518	30
31	V	32 Related Party Interest						31
32	V	34 Related Party Rent-Facility & Grounds				5,482	5,482	32
33	V	35 Related Party Rent - Equipment				209	209	33
34	V							34
35	V							35
36	V	PLEASE SEE CONTINUED DISCLOSURE AND DETAIL OF ADJUSTMENTS ON THE NEXT PAGE (6B)...						36
37	V							37
38	V							38
39	Total		\$ 257,754			\$ 110,318	\$ * (147,436)	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 Rental	\$ 484,255	Sterling Facility Company, LLC	100.00%	\$	\$ (484,255)	15
16	V				This facility company is under 100% common ownership				16
17	V				with ECTC, and therefore the "rent" paid to the facility				17
18	V				company has been removed from this report and the				18
19	V				actual expenses of the facility company have been				19
20	V				added here:				20
21	V	30	Related Party Depreciation		Sterling Facility Company, LLC		308,400	308,400	21
22	V	32	Related Party Interest (Net)		Sterling Facility Company, LLC		140,203	140,203	22
23	V	32	Related Party Amortization of Debt Cost		Sterling Facility Company, LLC		6,461	6,461	23
24	V	26	Related Party Insurance		Sterling Facility Company, LLC		34,368	34,368	24
25	V	36	Related Party Mortgage Insurance		Sterling Facility Company, LLC		28,901	28,901	25
26	V	19	Related Party Accounting Fees		Sterling Facility Company, LLC		9,347	9,347	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		PLEASE SEE CONTINUED DISCLOSURE AND DETAIL OF ADJUSTMENTS OF THE NEXT PAGE (6C):						37
38	V								38
39	Total			\$ 484,255			\$ 527,680	\$ * 43,425	39

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

Facility Name & ID Number

Exceptional Cr Training Ctr

0035477

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

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								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Exceptional Cr Training Ctr # 0035477 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	0.00					\$		1
2	John Gilmor	Board Member	Governance	0.00							2
3	Jim Ridenour	Board Member	Governance	0.00							3
4	Jo Anne Corbitt	Board Member	Governance	0.00							4
5	Douglass Smith	Board Member	Governance	0.00							5
6	Stephen Wood	Board Member	Governance	0.00							6
7	Laura Hawken	Board Member	Governance	0.00							7
8	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 Board of Directors of HCI										8
9	HCI affiliated facilities, Exceptional Care & Training Center, being one of many. Therefore, no Board Fees or compensation is paid directly by ECTC to the Directors,										9
10	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, including payment										10
11	payment by HCI to Board members of each legal entity. Fees paid by other IL facilities are shown on Page 7.1										11
12	The entire amount of fees included on this report, grouped on Line 18, is disclosed here at actual cost to the facility:							Admin Fees	72,542	18.8	12
13								TOTAL	\$ 72,542		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 REPO

Amounts Paid for Directors/Administration Fees by other Nursing Homes

Walter Lawson Children's Home	86,108
Swann Special Care Center	106,103
Exceptional Care & Training Center	72,542

RTS.

Facility Name & ID Number Exceptional Cr Training Ctr# 0035477

Report Period Beginning:

7/1/2019Ending: 5/30/2020

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 Excepti

Street Address

1050 Chinoe Road, Suite 350

City / State / Zip Code

Lexington, KY 40502

Phone Number

(859) 255-0075

Fax Number

(859) 571-5150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Direct Cost	117,678,712	17	\$ 25,678	\$	4,285,487	\$ 935	1
2	6	Maintenance	Direct Cost	117,678,712	17	2,359		4,285,487	86	2
3	17	Administrative	Direct Cost	117,678,712	17	1,876,404		4,285,487	68,333	3
4	19	Professional Services	Direct Cost	117,678,712	17	279,641		4,285,487	10,184	4
5	20	Dues, Fees, Subscriptions	Direct Cost	117,678,712	17	31,621		4,285,487	1,152	5
6	21	Clerical & General Office	Direct Cost	117,678,712	17	54,157		4,285,487	1,972	6
7	22	Employee Benefits & Payroll Tax	Direct Cost	117,678,712	17	316,789		4,285,487	11,536	7
8	23	Inservice Training & Education	Direct Cost	117,678,712	17	12,916		4,285,487	470	8
9	24	Travel & Seminar	Direct Cost	117,678,712	17	228,357		4,285,487	8,316	9
10	26	Insurance	Direct Cost	117,678,712	17	30,894		4,285,487	1,125	10
11	30	Depreciation	Direct Cost	117,678,712	17	14,214		4,285,487	518	11
12	32	Interest	Direct Cost	117,678,712	17	0		4,285,487	0	12
13	34	Rent - Facility & Grounds	Direct Cost	117,678,712	17	150,544		4,285,487	5,482	13
14	35	Rent - Equipment	Direct Cost	117,678,712	17	5,747		4,285,487	209	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,029,321	\$		\$ 110,318	25

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Medical Rehabilitation Centers, LLC dba Exceptional Living Centers

This facility allocation determines the percentage of allowable ELC expenses by building based on the % of each building's operating expenses compared to the total of operating expenses for all facilities under management.

Determination of % of Costs to be allocated to each facility under management: % of total Operating Direct Costs of the Facility to all Facilities under Mgmt

Facility	Operating Expense 07/19 - 03/20	Facility GL Mgmt Fee 07/19 - 03/20	Percent Alloc.	Actual Costs
1 Allis Care Center	10,243,689	-	8.70%	316,866
2 Exceptional Senior Living (Prospect)	1,688,153	108,440	1.43%	52,219
Total LHM	11,931,843		10.14%	369,086
3 Century Villa	5,242,689	397,397	4.46%	162,171
Subtotal Putnam Co Facilities	5,242,689		4.46%	162,171
4 Morning Breeze	3,932,363	143,690	3.34%	121,639
Subtotal AE Indiana Facilities	3,932,363		3.34%	121,639
5 Sanders Glen	1,862,308	186,545	1.58%	57,606
Subtotal QSH Facilities	1,862,308		1.58%	57,606
6 ELC Brazil	3,970,880	470,460	3.37%	122,831
7 Towne Park	709,086	43,965	0.60%	21,934
8 Randolph Nursing	4,279,507	327,528	3.64%	132,377
9 Richland Bean-Blossom	3,903,396	361,260	3.32%	120,743
10 Vernon Manor	4,895,315	357,702	4.16%	151,426
Subtotal ESG Indiana Facilities	17,758,185		15.09%	549,311
11 Exceptional Care Training Center	4,285,487	309,726	3.64%	132,562
12 Swann Special Care Center	6,871,153	449,172	5.84%	212,544
13 Walter Lawson	5,914,103	399,429	5.03%	182,940
Subtotal ESG Illinois Facilities	17,070,743		14.51%	528,046
14 Harbor	11,390,362	996,870	9.68%	352,336
15 Parkview	9,555,347	816,792	8.12%	295,574
16 Churchman	7,810,714	723,780	6.64%	241,607
Subtotal ESG East	28,756,423		24.44%	889,517
Total Hoosier Care	63,585,350		54.03%	1,966,874
17 Clifton Oaks Care Center	3,280,171	62,298	2.79%	101,465
18 Frankfort Care & Rehab	3,172,657	51,756	2.70%	98,139
19 Green Hill Rehab & Care	2,853,247	62,529	2.42%	88,259
20 Hillcreek Rehab & Care	4,566,816	76,344	3.88%	141,265
21 Kirtland Rehab & Care	3,305,980	66,452	2.81%	102,263
22 Lyndon Woods Care	3,537,929	65,687	3.01%	109,438
23 St Matthews Care Center	4,176,317	79,974	3.55%	129,185
24 Stanford Care & Rehab	3,698,724	67,414	3.14%	114,412
25 Vanceburg Rehab & Care	2,532,319	62,902	2.15%	78,332
Subtotal KYOH Group	31,124,159		26.45%	962,758
Total ELC Facilities Under Mgmt	117,678,712		100.00%	3,640,135

ILLINOIS

CR Line	Total for CR Line	ECTC SNF	
		ECTC	Allowable Only
5 Utilities	30,855	1,124	25,678
6 Maintenance	2,835	103	2,359
17 Administrative	2,254,751	82,111	1,876,404
19 Professional Services	336,027	12,237	279,641
20 Dues, Fees, Subscriptions	37,997	1,384	31,621
21 Clerical & General Office	65,077	2,370	54,157
22 Employee Benefits & Payroll Taxes	380,664	13,863	316,789
23 Inservice Training & Education	15,520	565	12,916
24 Travel & Seminar	274,401	9,993	228,357
25 Other Admin Staff Transportation			
26 Insurance	37,123	1,352	30,894
30 Depreciation	17,080	622	14,214
32 Interest	-	-	-
34 Rent - Facility & Grounds	180,899	6,588	150,544
35 Rent - Equipment	6,906	251	5,747
	3,640,135	132,562	3,029,320

To CR PG8 Col 6 total indirect cost being allocated

Gross GL Rel Pty Mgmt Fee Expens	SNF	EDU/DT	SNF	EDU/DT
309,726	257,754	51,972	83%	17%

Amts removed via EDU/DT Adj CR PG5A for L19 (See DT/EDU Alloc WP 2035 for % offset)

110,318 Allowable cost of Rel Pty Mgmt Co to now be reclassified to functional expense lines below

Exceptional Care Training Center

IL CR Line	Percentage of grouped CR Li Amt to reclass to CR Lines	
5 Utilities	0.85%	935 To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
6 Maintenance	0.08%	86 To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
17 Administrative	61.94%	68,333 To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
19 Professional Services	9.23%	10,184 To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
20 Dues, Fees, Subscriptions	1.04%	1,152 To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
21 Clerical & General Office	1.79%	1,972 To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
22 Employee Benefits & Payroll Taxes	10.48%	11,536 To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
23 Inservice Training & Education	0.43%	470 To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
24 Travel & Seminar	7.54%	8,316 To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
25 Other Admin Staff Transportation	0.00%	- To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
26 Insurance	1.02%	1,125 To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
30 Depreciation	0.47%	518 To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
32 Interest	0.00%	- To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
34 Rent - Facility & Grounds	4.97%	5,482 To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
35 Rent - Equipment	0.19%	209 To CR PG6 Col 7 allowable cost of Rel Pty Mgmt Co
	100.00%	110,318

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	\$26,513.35	11/1/2012	\$ 6,675,000	\$ 5,448,569	11/01/2042	0.0254	\$ 140,203	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	GE Healthcare Finance		X			6/24/14	5,750,000		10/27/19	Variable		6	
7												7	
8												8	
9	TOTAL Facility Related				\$26,513.35		\$ 12,425,000	\$ 5,448,569			\$ 140,203	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	\$ 5,448,569			\$ 140,203	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 28,901 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

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2020 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:		2015		8	
		2016		9	
		2017		10	
		2018		11	
		2019		12	
Note: This facility became exempt from Property Taxes starting on 01/01/1996					
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2019	\$	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.

FACILITY NAME Exceptional Cr 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 2019 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 2019.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

31,176

B. General Construction Type:

Exterior

Brick

Frame

Wood

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(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 removed associated costs shown on Sch. V; See PG 11.2 Attachment 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 Care & Training Center
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 dediciated GL accounts, including wages/salaries, supplies, rent and occupancy costs, have been grouped in line 43 of Schedule V, "Other Costs 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 allocated 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 aplied 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.

Facility Name & ID Number Exceptional Cr Training Ctr

0035477

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	64		1989		\$ 2,334,000	\$ 58,000	10-35	\$ 58,000	\$	\$ 2,097,166	4
5	15			1991	358,311	11,944	30	11,944		346,925	5
6	5			2004							6
7											7
8											8
	Improvement Type**										
9	TILE FOR FLOORS IN TUB RO			2/16/1995	4,405		10			4,405	9
10	THERMOCOUPLE ON BOILER			3/8/1995	2,550		10			2,550	10
11	REPLACE FIRE ALARM			6/30/1995	3,743		10			3,743	11
12	PART:GENERATOR,TRANSFER S			9/11/1998	2,746		10			2,746	12
13	INSTALL TILE:WALLS,STAIRC			12/2/1998	4,495		10			4,495	13
14	2 HOT WATER TANKS			3/5/1999	7,119		10			7,119	14
15	COOLING SYSTEM-LAUNDRY/KI			1/22/2000	4,650	116	20	116		4,650	15
16	NEW TILE IN DINING RM/CLA			4/11/2000	4,770		15			4,770	16
17	FURNISH & INSTALL AWNING.			4/6/2001	2,771		15			2,771	17
18	LABOR & MAT-BREAKER PANEL			4/12/2001	3,930		15			3,930	18
19	INSTALL WATER HEATER			7/5/2001	3,341		15			3,341	19
20	INTERNET SET-UP-WIRING CA			2/21/2002	3,061		15			3,061	20
21	STORM WINDOW PROJECT			6/24/2002	8,937	447	20	447		8,081	21
22	NEW ELECTRICAL SYSTEM (MULIT PURPOSE RM			9/9/2004	6,637		7			6,637	22
23	34 HEAT/SMOKE DETECTORS			12/2/2004	2,800		7			2,800	23
24	REPLACE COMPRESSOR IN LOBBY			8/9/2005	11,445	763	15	763		11,381	24
25	WATER HEATER			6/16/2006	4,717		10			4,717	25
26	SPRINKLER SYSTEM-PHASE I			6/30/2006	33,165	2,211	15	2,211		30,954	26
27	SPRINKLER SYSTEM-PHASE II			6/30/2006	7,920	528	15	528		7,392	27
28	SPRINKLER SYSTEM-PHASE III			9/21/2006	13,365	891	15	891		12,251	28
29	LIGHT FIXTURES (24) AND NEW WIRING			1/22/2007	6,434	429	15	429		5,755	29
30	DUCTWORK & ROOF EXHAUST FOR NEW DRYER			3/15/2007	3,498	233	15	233		3,109	30
31	BRAKE ASSEMBLY ON DUMBWAITER			7/24/2007	4,389	293	15	293		3,779	31
32	PRIVACY WALL IN DAY ROOMS (2)			6/6/2008	3,297	220	15	220		2,656	32
33	WIRING & OUTLETS FOR KITCHEN & DAYROOMS			9/26/2008	3,434	229	15	229		2,690	33
34	EXIT & BOILER ROOM DOORS REPLACED			12/18/2008	2,712	181	15	181		2,079	34
35	AVAYA PHONE SYSTEM FOR DAY TRAINING			5/21/2009	7,010		10			7,010	35
36	5 TON ROOFTOP HVAC UNIT			7/9/2009	6,485	432	15	432		4,756	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Exceptional Cr Training Ctr

0035477

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

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	26 X 12 STORAGE SHED	7/12/2009	\$ 8,280	\$ 552	15	\$ 552	\$	\$ 6,072	37
38	WATER HEATERS (2)	8/13/2009	11,250	94	10	94		11,250	38
39	GREASE TRAP REPLACED AND ELECTRIC & TILE	5/20/2010	7,217	481	15	481		4,852	39
40	ROOF FOR COURTYARD PAVILLION	5/28/2010	6,657	444	15	444		4,475	40
41	TILE WORK FOR WALLS IN SOUTH & EAST HALL	7/15/2010	11,594	1,159	10	1,159		11,594	41
42	MISC ELECTRICAL WORK	10/6/2010	4,915	328	15	328		3,195	42
43	MAIN DRAIN LINE REPLACED	10/9/2010	2,818	188	15	188		1,832	43
44	PARAPET WALL ON ROOF	10/28/2010	8,215	411	20	411		3,971	44
45	REMODEL RESTROOM FOR ISOLATION ROOM	2/28/2011	2,556	256	10	256		2,386	45
46	TILE IN LOBBY AND SURROUNDING AREAS	6/14/2011	3,274	327	10	327		2,974	46
47	ROOF HVAC UNITS (2)	10/3/2011	8,173	817	10	817		7,151	47
48	WATER HEATER FOR SOUTH WING	10/4/2011	7,937	794	10	794		6,945	48
49	REPLACE HEADER ON BASEMENT DOOR	12/7/2011	4,870	325	15	325		2,787	49
50	MEDICAL ROOM REMODEL	12/1/2012	8,082	808	10	808		6,129	50
51	BOILER	3/1/2013	22,525	1,502	15	1,502		11,012	51
52	BRYANT A/C UNITS (2) AND DISHWASHER HOOD	4/12/2013	13,875	925	15	925		6,706	52
53	BOILER REPAIR/REPLACEMENT	7/23/2013	29,683	2,968	10	2,968		20,531	53
54	NURSES STATION REMODEL	8/15/2013	19,747	1,975	10	1,975		13,658	54
55	NURSES STATION REMODEL	10/2/2013	19,748	1,975	10	1,975		13,330	55
56	REPLACED FIRE DOOR	10/3/2013	5,615	561	10	561		3,790	56
57	NEW DUMBWAITER	12/20/2013	10,898	1,090	10	1,090		7,084	57
58	INSTALLATION OF DUMBWAITER	4/10/2014	21,797	2,180	10	2,180		13,623	58
59	NEW TILE	6/12/2014	2,578	258	10	258		1,569	59
60	EMERGENCY GENERATOR	7/31/2014	12,810	1,281	10	1,281		7,579	60
61	EMERGENCY GENERATOR	7/31/2014	10,775	1,077	10	1,077		6,375	61
62	EMERGENCY GENERATOR	7/31/2014	10,775	1,077	10	1,077		6,375	62
63	REPLACE DRY WALL IN 3 ROOMS	11/7/2014	2,950	295	10	295		1,672	63
64	NEW METAL DOORS	11/19/2014	5,635	564	10	564		3,146	64
65	REPLACED DRAIN LINE IN KITCHEN	11/19/2014	2,700	270	10	270		1,508	65
66	3 BATHROOM REMODELS	12/10/2014	4,185	419	10	419		2,337	66
67	NEW ROOF	12/30/2014	7,350	735	10	735		4,043	67
68	NEW ROOF	12/30/2014	6,000	600	10	600		3,300	68
69	NEW ROOF	12/30/2014	5,950	595	10	595		3,259	69
70	TOTAL (lines 4 thru 69)		\$ 3,177,572	\$ 104,246		\$ 104,246	\$	\$ 2,814,228	70

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

Facility Name & ID Number Exceptional Cr Training Ctr

0035477

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

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		\$ 3,177,572	\$ 104,246		\$ 104,246	\$	\$ 2,814,228	1
2	INSTALLED FRP BOARD IN SEVERAL AREAS	3/19/2015	3,010	301	10	301		1,580	2
3	BEDROOM/BATH REMODEL	5/20/2015	60,000	6,000	10	6,000		30,500	3
4	Q OFFICE & CONF ROOM REPAIRS	10/8/2015	3,341	334	10	334		1,587	4
5	BEDROOM/BATH REMODEL	11/19/2015	40,000	4,000	10	4,000		18,333	5
6	BEDROOM/BATH REMODEL	1/16/2016	28,040	2,804	10	2,804		12,384	6
7	REPAIRS TO DOUBLE FIRE DOORS	4/1/2016	2,752	275	10	275		1,170	7
8	DOOR HARDWARE, WALL/DOOR PANELS-1ST PMT	6/24/2016	15,000	1,500	10	1,500		6,000	8
9	HALLWAY HANDRAILS - 1ST PMT	6/24/2016	5,000	500	10	500		2,000	9
10	DOOR HARDWARE, WALL/DOOR PANELS-FINAL	7/12/2016	14,760	1,476	10	1,476		5,904	10
11	HALLWAY HANDRAILS - FINAL PMT	7/12/2016	4,650	465	10	465		1,860	11
12	FIRE DOOR COOLERS	7/22/2016	2,880	288	10	288		1,128	12
13	DOOR COOLER	8/9/2016	3,250	325	10	325		1,273	13
14	CABINETS & COUNTERS	9/26/2016	5,682	568	10	568		2,131	14
15	COMPRESSOR FOR HVAC UNIT	10/27/2016	3,028	303	10	303		1,110	15
16	TUB ROOM REMODEL - 5%	11/30/2016	26,530	2,653	10	2,653		9,507	16
17	CEILING LIFTS	11/30/2016	4,986	499	10	499		1,787	17
18	TILE INSTALLATION	12/7/2016	4,481	448	10	448		1,606	18
19	REPLACE PICTURE WINDOWS	12/13/2016	21,730	2,173	10	2,173		7,787	19
20	CEILING LIFTS	12/21/2016	7,807	781	10	781		2,732	20
21	CEILING LIFTS	12/29/2016	6,800	680	10	680		2,380	21
22	CABINETS	2/16/2017	4,685	468	10	468		1,562	22
23	WINDOWS REPLACED	3/2/2017	10,532	1,053	10	1,053		3,511	23
24	HOPPER SINK & FLUSH VALVE INSTALLED	4/20/2017	5,225	522	10	522		1,655	24
25	FIRE ALARM	4/28/2017	4,598	460	10	460		1,456	25
26	SHOWER RENOVATION 4%	6/30/2017	19,973	1,997	10	1,997		5,992	26
27	SHOWER RENOVATION 3%	6/30/2017	14,980	1,498	10	1,498		4,494	27
28	SHOWER RENOVATIONS	6/30/2017	12,800	1,280	10	1,280		3,840	28
29	SHOWER RENOVATION	6/30/2017	12,483	1,248	10	1,248		3,745	29
30	VINYL FLOORING - DOWN PAYMENT	12/15/2017	80,937	8,094	10	8,094		20,909	30
31	VINYL FLOORING	12/15/2017	20,000	2,000	10	2,000		5,167	31
32	VINYL FLOORING	12/15/2017	20,000	2,000	10	2,000		5,167	32
33	INSTALL CELING GRID SPRINKLERS	5/12/2018	2,564	256	10	256		555	33
34	TOTAL (lines 1 thru 33)		\$ 3,650,077	\$ 151,497		\$ 151,497	\$	\$ 2,985,038	34

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

Facility Name & ID Number Exceptional Cr Training Ctr

0035477

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

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		\$ 3,650,077	\$ 151,497		\$ 151,497	\$	\$ 2,985,038	1
2	NEW CABINETS	6/26/2018	7,576	758	10	758		1,515	2
3	STORAGE SHED FINAL PAYMENT	10/18/2018	7,806	781	10	781		1,301	3
4	WATER SOFTENER	12/4/2018	6,000	600	10	600		950	4
5	NEW FIRE DOORS	12/20/2018	4,565	456	10	456		685	5
6	OFFICE REMODEL/CONVERSION	12/31/2018	3,403	340	10	340		510	6
7	BASEMENT REMODEL	1/7/2019	2,808	281	10	281		421	7
8	BOILER REPAIRS	1/8/2019	4,883	488	10	488		732	8
9	WATER HEATER	1/15/2019	6,800	680	10	680		1,020	9
10	WALL LEAK REPAIRS	7/21/2019	3,755	344	10	344		344	10
11	DEPOSIT FOR CABINETS	11/21/2019	7,910	461	10	461		461	11
12	PLUMBING REPAIR WORK	1/31/2020	7,712	321	10	321		321	12
13	FINAL PAYMENT FOR CABINETS	2/9/2020	9,438	393	10	393		393	13
14	GATE & FENCE SCARS	5/29/1992	4,038		10			4,038	14
15	NEW WATER MAIN	10/11/1993	12,204		10			12,204	15
16	RESEAL PARKING AREA	6/7/1997	2,845		10			2,845	16
17	TANK REPLACEMENT - PIPECO	9/28/1998	9,890		20			9,890	17
18	EXCAVATION OF NEW PARKING	5/11/2001	12,415	621	20	621		11,898	18
19	WALKWAY	8/28/2001	4,119		15			4,119	19
20	PRIVACY FENCE	6/20/2002	2,550		10			2,550	20
21	PARKING LOT RENOVATION	9/11/2004	3,499		10			3,499	21
22	PORTIONS OF PARKING LOT REPLACED/RESURFA	10/20/2008	3,670		10			3,670	22
23	CONCRETE SIDEWALK FOR EMERGENCY EXIT	7/26/2009	7,119	475	15	475		5,181	23
24	TREX SECURITY FENCE	9/28/2009	9,142	609	15	609		6,552	24
25	GREENHOUSE FOR THERAPY USE	12/22/2010	12,475	1,248	10	1,248		11,851	25
26	RENTENTION POND	6/6/2011	7,273	727	10	727		6,606	26
27	HARDSCAPE & LANDSCAPE FOR RENTENTION PON	6/6/2011	3,936	394	10	394		3,575	27
28	VINYL COATED CHAIN LINK FENCE	6/7/2011	6,475	648	10	648		5,881	28
29	REPLACE SIDEWALKS	9/20/2011	6,617	662	10	662		5,790	29
30	REPAVE PARKING LOT	11/1/2013	54,183	5,418	10	5,418		36,122	30
31	REPAVE PARKING LOT	11/1/2013	49,636	4,964	10	4,964		33,091	31
32	CONCRETE DUMPSTER PAD	10/8/2014	8,970	897	10	897		5,158	32
33	SIDEWALK SECTION REPLACED	8/29/2016	3,299	330	10	330		1,264	33
34	TOTAL (lines 1 thru 33)		\$ 3,947,087	\$ 174,392		\$ 174,392	\$	\$ 3,169,478	34

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

Facility Name & ID Number Exceptional Cr Training Ctr

0035477

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

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		\$ 3,947,087	\$ 174,392		\$ 174,392	\$	\$ 3,169,478	1
2	NEW SHED	7/14/2019	2,875	288	10	288		288	2
3	INSTALL NEW SEWER LINES	7/14/1993	4,105		10			4,105	3
4	REPLACE PARTS ON 2 SUMP P	5/24/1994	4,034		10			4,034	4
5	SEWAGE PUMP	2/7/2009	4,133		10			4,133	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,962,233	\$ 174,680		\$ 174,680	\$	\$ 3,182,037	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	\$ 324,998	\$ 54,249	\$ 54,249	\$	5-7	\$ 194,586	71
72	Current Year Purchases	53,056	7,201	7,201		5-10	4,790	72
73	Fully Depreciated Assets	801,198	3,766	3,766			801,077	73
74	Depr Exp (Net Allowable) - Rel. Party Alloc Sch VIII		518	518				74
75	TOTALS	\$ 1,179,252	\$ 65,734	\$ 65,734	\$		\$ 1,000,453	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	\$ 36,453
77									
78									
79									
80	TOTALS			\$ 41,267	\$ 4,127	\$ 4,127	\$		\$ 36,453

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)			\$ 5,596,837	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 244,541	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 244,541	
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)			\$ 4,218,943	

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	\$ 244,123	\$ 2,975	\$ 244,123
87	Assets Below IL Capital Threshold/Other	668,948	31,032	570,334
88	Assets Disallowed by HFS Cap Review	654,912	30,370	379,672
89				
90				
91	TOTALS	\$ 1,567,983	\$ 64,377	\$ 1,194,129

G. Construction-in-Progress		
	Description	Cost
92	Door Systems	\$ 12,054
93		
94		
95		\$ 12,054

* 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		5,482	10	10	5
6								6
7	TOTAL				\$ 5,482			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: \$ 6,426 Description: Copiers/Scanners - Canon Financial Services - \$6,124; Airgas USA - Clinical Equipment - \$302
(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. 6/30/2021 \$ Home Office Alloc Amt

13. 6/30/2022 \$ Home Office Alloc Amt

14. 6/30/2023 \$ 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		664		664
3	Classroom Wages (a)		24,573		24,573
4	Clinical Wages (b)		39,317		39,317
5	In-House Trainer Wages (c)		4,914		4,914
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 69,468	\$	\$ 69,468
10	SUM OF line 9, col. 1 and 2 (e)	\$ 69,468			

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	24
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	24

(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			2,662			2,662	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.1	162 hrs	11,206				162	11,206	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		80	5,303		80	5,303	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	39.3	hrs			2,443			2,443	10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):	Note: Lines 2 and 10 are paid flat, monthly fees and do not report hours.								13
14	TOTAL			\$ 11,206	80	\$ 10,408	\$	242	\$ 21,614	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.				
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	\$ 2,940,636	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (16,275))	811,151		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	100,595		6
7	Other Prepaid Expenses	7,717		7
8	Accounts Receivable (owners or related parties)	19,616,888		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 23,476,987	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec Patient Trust Bank Ac	139,287		22
23	Other(specify): Goodwill	396,154		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 535,441	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 24,012,428	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 123,249	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	299,283		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	144,467		36
37	Patient Trust Liability	139,287		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 706,286	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Rounding	(20)		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (20)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 706,266	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 23,306,162	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 24,012,428	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 20,922,322	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 20,922,322	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,383,840	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)	\$ 2,383,840	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)	\$ 23,306,162	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Exceptional Cr Training Ctr

0035477

Report Period Beginning: 7/1/2019

Ending:

6/30/2020

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	\$ 7,406,301	1
2	Discounts and Allowances for all Levels	8,235	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,414,536	3
	B. Ancillary Revenue		
4	Day Care	1,748,556	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,748,556	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	58,921	11
12	Gift and Coffee Shop	892	12
13	Barber and Beauty Care	11	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)	\$ 59,824	23
	D. Non-Operating Revenue		
24	Contributions	64,701	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 64,701	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Gain/Loss on Investments</u>	100	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 100	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,287,717	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	920,622	31
32	Health Care	2,520,641	32
33	General Administration	1,773,154	33
	B. Capital Expense		
34	Ownership	497,163	34
	C. Ancillary Expense		
35	Special Cost Centers	838,753	35
36	Provider Participation Fee	353,544	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,903,877	40
41	Income before Income Taxes (line 30 minus line 40)**	2,383,840	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,383,840	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 7,393,409	44
45	Private Pay - Net Inpatient Revenue	21,252	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify) <u>Bad Debt</u>	(125)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,414,536	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	2,080	2,080	\$ 93,899	\$ 45.14	1
2	Assistant Director of Nursing	1,893	2,018	74,886	37.11	2
3	Registered Nurses	4,876	5,206	176,120	33.83	3
4	Licensed Practical Nurses	18,207	19,856	590,589	29.74	4
5	CNAs & Orderlies	68,304	73,447	1,139,370	15.51	5
6	CNA Trainees					6
7	Licensed Therapist	162	162	11,206	69.17	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,797	2,081	36,365	17.47	9
10	Activity Assistants	15,595	16,289	184,186	11.31	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,586	1,853	43,044	23.23	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,002	11,871	145,128	12.23	15
16	Dishwashers					16
17	Maintenance Workers	11,644	12,613	184,344	14.62	17
18	Housekeepers	1,437	1,699	33,040	19.45	18
19	Laundry	10,803	11,736	147,575	12.57	19
20	Administrator	2,080	2,080	160,492	77.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,737	4,138	98,089	23.70	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	43,364	46,643	755,601	16.20	33
34	TOTAL (lines 1 - 33)	196,567	213,772	\$ 3,873,934 *	\$ 18.12	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	108	\$ 6,471	1.3	35
36	Medical Director	N/A	25,193	9.3	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)	108	\$ 31,664		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

A. Administrative Salaries			
Name	Function	%	Amount
Melissa Francque	Administrator	0	\$ 160,492
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 160,492
B. Administrative - Other			
Description			Amount
			\$
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 Exceptional Livir	Management Services		\$ 309,726
Various (See attachment)	Legal Services		67,869
Various	Accounting Services		13,231
Grace Financial Services	Management Services		121,819
ADP/Payor	Payroll Processing		19,378
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 532,023
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 61,206
Unemployment Compensation Insurance			(42,932)
FICA Taxes			229,434
Employee Health Insurance			329,068
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
401K Retirement Plan			16,995
Other			19,886
Group Allocation - PG8			11,536
Less PG5A Non-Allowable DT			(127,199)
Employee Physicals			40
TOTAL (agree to Schedule V, line 22, col.8)			\$ 498,034
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 1,825
Advertising: Employee Recruitment			8,560
Health Care Worker Background Check (Indicate # of checks performed)			1,504
Bank Fees			(646)
Professional Fees			235
Other Dues, Fees, Subs			5,408
Less PG5A Non-Allowable DT			(6,757)
Non-Allowable Lobbying			(1,450)
Group Allocation - PG8			1,152
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 9,831
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
N/A			
In-State Travel			
See PG 21.2 for Detail			6,001
Less PG5 Non-Allowable Items			(1,585)
Corporate/Group Travel Alloc - G&A			8,316
Seminar Expense			
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 12,732

*** Attach copy of IMRF notifications**

****See instructions.**

Date	Description	Amount
7/31/2019	Group Invoices paid from ELC	113
9/30/2019	Group Invoices paid from ELC	68
9/30/2019	KC - legal fees accrual 09.19	509
10/31/2019	KC - legal fees accrual 09.19	(509)
10/31/2019	Group Invoices paid from ELC	60
10/31/2019	Client/Matter: 2928856.000002	509
11/30/2019	Group Invoices paid from ELC	34
12/31/2019	Group Invoices paid from ELC	1,934
1/31/2020	Group Invoices paid from ELC	2,208
2/29/2020	Fiole # G9779-00001	14,399
2/29/2020	Repay HCI for inv paid	27,259
2/29/2020	kc - rcls legal fees	2,558
3/31/2020	Group Invoices paid from ELC	1,043
4/29/2020	Baker, Donelson, Bearman, Caldwe	1,331
4/29/2020	Baker, Donelson, Bearman, Caldwe	136
4/30/2020	Exceptional Living Centers	1,043
4/30/2020	RCL Duane Morris Legal Fees	1,800
4/30/2020	Reverse EHC group invoice ECTC03312020	(1,043)
5/20/2020	Duane Morris LLP	9,869
5/20/2020	Duane Morris LLP	510
6/10/2020	Baker, Donelson, Bearman, Caldwe	1,855
6/10/2020	Cruser, Mitchell.Novitz,Sanchez	688
6/30/2020	Baker, Donelson, Bearman, Caldwe	1,495
		<u>67,869</u>

See Schedule VI for adjustment for unallowable portion.

Description	Amount	Sch. V Line.Col
<u>In-State Travel</u>		
1 Rudy Johnathon, Mock Survey	2,395	24.3
2 Hoosier Care Inc, Kylie Waters	175	24.3
3 Irene Mireles, DT Assistant, Resident Needs	82 A	24.3
4 Jamie Cervantez, DON, Meetings/Referrals	75	24.3
5 Jennifer Michels, Activity Director, Resident Needs	86	24.3
6 Melissa Francque, Executive Director, Meetings/Referrals, IHCA	2,443	24.3
7 Paula Scheller, DT Program Director, Meetings/Referrals	65 A	24.3
8 Samantha Schrader, DT QMRP, Resident Needs	144	24.3
9 Wynnell Eakle, BOM, Meetings/Referrals	24	24.3
10 Miscellaneous Travel, Other non-care related	512 A	24.3
Total In-State Travel	<u>6,001</u>	
Line 24 Column 4 Total:	6,001	
Line 24 Column 7 Adjustment - Corporate/Home Office Allocated Costs:	8,316	
Line 24 Column 6 Total:	<u>14,317</u>	
Non-allowable Amounts above removed through Sch 5 Adjustments:		
Non-Care related amounts noted above:	(659) A	
Allocation for non-care related travel (See Pg 11.2 & 5A)	(926)	
Line 24 Column 8 Total:	<u>12,732</u>	
	-	

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ILHCA; \$3,958 net after Sch. VI Adj

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____

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

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7.65 years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 59,236 Line 10

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

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

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 353,544
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)

(14)

(15)

(16)

(17)

(18)

(19)

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

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

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

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. \$ 225

Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Crowe, LLP

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

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