

Facility Name & ID Number Exceptional Care & Training Center

0035477 Report Period Beginning: 07/01/99 Ending: 06/30/00

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 _____

	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	79	Skilled Pediatric (SNF/PED)	79	28,914	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	79	TOTALS	79	28,914	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED	28,749	22		28,771	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,749	22		28,771	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.51%

D. How many bed-hold days during this year were paid by Public Aid? 18 (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 08/15/89

J. Was the facility purchased or leased after January 1, 1978?
YES Date 08/15/89 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified N/A and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 06/30/00 Fiscal Year: 06/30/00

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

STATE OF ILLINOIS

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Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/99 Ending: 06/30/00

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	136,024	14,951	2,856	153,831		153,831		153,831		1
2	Food Purchase		114,003		114,003		114,003		114,003		2
3	Housekeeping	76,012	11,018		87,030		87,030		87,030		3
4	Laundry	97,240	10,678		107,918		107,918		107,918		4
5	Heat and Other Utilities			65,971	65,971		65,971		65,971		5
6	Maintenance	60,417	6,830	23,342	90,589		90,589		90,589		6
7	Other (specify):*										7
8	TOTAL General Services	369,693	157,480	92,169	619,342		619,342		619,342		8
	B. Health Care and Programs										
9	Medical Director			12,700	12,700		12,700		12,700		9
10	Nursing and Medical Records	1,185,804	73,903	10,713	1,270,420		1,270,420		1,270,420		10
10a	Therapy	14,377		19,184	33,561		33,561		33,561		10a
11	Activities	148,723	2,408		151,131		151,131		151,131		11
12	Social Services			139	139		139		139		12
13	Nurse Aide Training	9,214			9,214		9,214		9,214		13
14	Program Transportation		703	51	754		754		754		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,358,118	77,014	42,787	1,477,919		1,477,919		1,477,919		16
	C. General Administration										
17	Administrative	53,479		68,288	121,767	(67,508)	54,259	(780)	53,479		17
18	Directors Fees					6,130	6,130		6,130		18
19	Professional Services			311,898	311,898	19,863	331,761		331,761		19
20	Dues, Fees, Subscriptions & Promotions			7,809	7,809	361	8,170	(1,054)	7,116		20
21	Clerical & General Office Expenses	43,545	10,105	8,567	62,217	22,448	84,665	(61)	84,604		21
22	Employee Benefits & Payroll Taxes			403,304	403,304	3,567	406,871		406,871		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,793	5,793	2,123	7,916	(307)	7,609		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			13,734	13,734		13,734		13,734		26
27	Other (specify):* Bad Debts			200	200		200	(200)			27
28	TOTAL General Administration	97,024	10,105	819,593	926,722	(13,016)	913,706	(2,402)	911,304		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,824,835	244,599	954,549	3,023,983	(13,016)	3,010,967	(2,402)	3,008,565		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Exceptional Care & Training Center #0035477 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			111,374	111,374	80	111,454		111,454		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			355,414	355,414	12,972	368,386	127,943	496,329		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			4,109	4,109	(36)	4,073		4,073		35
36	Other (specify):* Amortization			29,581	29,581		29,581	146,935	176,516		36
37	TOTAL Ownership			500,478	500,478	13,016	513,494	274,878	788,372		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			239,744	239,744		239,744		239,744		42
43	Other (specify):* Day Training	483,907		12,218	496,125		496,125		496,125		43
44	TOTAL Special Cost Centers	483,907		251,962	735,869		735,869		735,869		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,308,742	244,599	1,706,989	4,260,330		4,260,330	272,476	4,532,806		45

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

Facility Name & ID Number **Exceptional Care & Training Center**

0035477

Report Period Beginning: 07/01/99

Ending: 06/30/00

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(30,799)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				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				18
19	Entertainment				19
20	Contributions	(123)	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	(200)	27		24
25	Fund Raising, Advertising and Promotional	(1,054)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached	305,432			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 273,256		\$	30

OHF 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)	(780)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (780)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 272,476		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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

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NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Goodwill Amortization	\$ (28,759)	36	1
2	Miscellaneous Income	62	21	2
3	Travel Out of State	(307)	24	3
4	Loss on Early Extinguishment of Debt	158,742	32	4
5	Loss on Early Extinguishment of Debt	167,694	36	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
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85				85
86				86
87				87
88				88
89				89
90	Total	305,432		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Exceptional Care & Training Center# 0035477

Report Period Beginning:

07/01/99

Ending:

06/30/00

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	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	Nurse Aide 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	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(780)	0	0	0	0	0	0	0	0	0	(780)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,054)	0	0	0	0	0	0	0	0	0	0	(1,054)	20
21	Clerical & General Office Expenses	(61)	0	0	0	0	0	0	0	0	0	0	(61)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(307)	0	0	0	0	0	0	0	0	0	0	(307)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(200)	0	0	0	0	0	0	0	0	0	0	(200)	27
28	TOTAL General Administration	(1,622)	(780)	0	0	0	0	0	0	0	0	0	(2,402)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,622)	(780)	0	0	0	0	0	0	0	0	0	(2,402)	29

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/99 Ending: 06/30/00

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	Bruce Hutson, M.D.	Director	Board Meetings	0.00	9,849			Director Fees	\$ 1,520	18.8	1
2	Stephen Wood	Director	Board Meetings	0.00	9,849			Director Fees	1,520	18.8	2
3	John Gillmor	Director	Board Meetings	0.00	9,849			Director Fees	1,520	18.8	3
4	John Foos	Director	Board Meetings	0.00	5,084			Director Fees	785	18.8	4
5	Michael Conn	Director	Board Meetings	0.00	5,082			Director Fees	785	18.8	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 6,130		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

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/99 Ending: 06/30/00

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

Name of Related Organization Hoosier Care, Inc.
 Street Address 535 West Second, Suite 105
 City / State / Zip Code Lexington, Kentucky 40508
 Phone Number (859) 255-0075
 Fax Number (859) 281-5150

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

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	18	Director's Fees	Revenue	36,997,938	8	\$ 45,843	\$ 0	4,947,475	\$ 6,130	1
2	19	Professional Services	Revenue	36,997,938	8	148,540	0	4,947,475	19,863	2
3	20	Fees, Subscription & Promotion	Revenue	36,997,938	8	997	0	4,947,475	133	3
4	21	Clerical & General Office Exp.	Revenue	36,997,938	8	167,599	0	4,947,475	22,412	4
5	22	Emp. Benefits & Payroll Tax	Revenue	36,997,938	8	28,380	0	4,947,475	3,795	5
6	24	Travel & Seminar	Revenue	36,997,938	8	15,875	0	4,947,475	2,123	6
7	30	Depreciation	Revenue	36,997,938	8	597	0	4,947,475	80	7
8	32	Interest Expense	Revenue	36,997,938	8	97,010	0	4,947,475	12,972	8
9										9
10										10
11										11
12										12
13										13
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15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 504,841	\$		\$ 67,508	25

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/99 Ending: 06/30/00

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		8	9	10									
						Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES							NO	Original				Balance
A. Directly Facility Related																			
Long-Term																			
1	City of Sterling Bonds-1989A		X	Purchase of Facility	Varies	08/01/89	\$ 4,875,000	\$	08/01/19	9.7500	\$	1							
2	City of Sterling Bonds-1999A		X	Purchase of Facility	Varies	07/08/99	4,775,000	4,745,000	06/01/34	7.1250	333,069	2							
3	City of Sterling Bonds-1999B		X	Purchase of Facility	Varies	07/08/99	220,000	215,000	06/01/19	10.5000	22,345	3							
4												4							
5												5							
Working Capital																			
6	Home Office Allocation										12,972	6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 9,870,000	\$ 4,960,000			\$ 368,386	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 9,870,000	\$ 4,960,000			\$ 368,386	15							

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

(See instructions.)

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

(See instructions.)

Facility Name & ID Number Exceptional Care & Training Center# 0035477 Report Period Beginning:07/01/99 Ending:06/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,676 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1C. 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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NoneF. 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	<u>SNF/PED Facility</u>	<u>63,598</u>	<u>1989</u>	<u>\$ 414,085</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	63,598		\$ 414,085	3

Facility Name & ID Number Exceptional Care & Training Center# 0035477

Report Period Beginning:

07/01/99

Ending:

06/30/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	64		1989		\$ 2,334,000	\$ 60,534	10-35	\$ 60,534	\$	\$ 937,166	4
5	15			1991	358,311	11,943	30	11,943		108,047	5
6											6
7											7
8											8
	Improvement Type**										
9		Boiler Repair		1990	964	57	10	57		964	9
10		Water Unit		1991	8,780	878	10	878		7,974	10
11		PA System		1991	696	70	10	70		628	11
12		Building Addition - Drywall		1991	403	40	10	40		362	12
13		Closet Curtain Track		1991	650	65	10	65		580	13
14		Door		1991	1,614	161	10	161		1,384	14
15		Boiler Repair		1992	6,180	618	10	618		5,219	15
16		Storm Windows		1992	907	91	10	91		765	16
17		Boiler Tubes		1992	7,147	715	10	715		5,957	17
18		Roof		1992	11,118	1,112	10	1,112		9,264	18
19		Kitchen Tile		1992	3,660	366	10	366		3,020	19
20		Heating & Cooling Unit		1992	7,757	776	10	776		6,271	20
21		Shed		1992	1,678	168	10	168		1,371	21
22		Gate & Fence Scars		1992	4,038	404	10	404		3,299	22
23		Landscaping		1992	2,398	240	10	240		1,939	23
24		Drain Replacement		1992	1,576	158	10	158		1,341	24
25		Black Top		1992	575	57	10	57		448	25
26		Light Fixtures		1992	3,743	374	10	374		2,993	26
27		Building Renovation		1993	139	5	30	5		39	27
28		Painting - Laundry		1993	351	35	10	35		281	28
29		Building Renovation		1993	7,106	711	10	711		5,153	29
30		Painting - Laundry		1993	262	26	10	26		189	30
31		Parking Lot		1993	1,800	180	10	180		1,275	31
32		Tile Installation		1993	1,020	102	10	102		737	32
33		Electrical Work		1993	3,255	326	10	326		2,362	33
34		Pipe Installation - Laundry		1993	156	16	10	16		113	34
35		Water Heater Renovation		1993	849	85	10	85		602	35
36	TOTAL (lines 4 thru 35)				\$ 2,771,133	\$ 80,313		\$ 80,313	\$	\$ 1,109,743	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.

Facility Name & ID Number Exceptional Care & Training Center# 0035477

Report Period Beginning:

07/01/99

Ending:

06/30/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Bed* ^s	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		Final Payment - Laundry	1993		1,030	103	10	103		729	9
10		Replace Relay in Panel	1993		1,150	115	10	115		786	10
11		Install New Sewer Lines	1993		4,105	411	10	411		2,876	11
12		New Water Main	1993		12,204	1,219	10	1,219		8,233	12
13		Replace Parts on Sump Pumps	1994		4,034	403	10	403		2,486	13
14		Installed Back Flow Preventor	1994		1,053	105	10	105		630	14
15		Large Toilet Support, Back Stop	1994		923	92	10	92		529	15
16		Deck	1994		814	81	10	81		459	16
17		New Roof	1994		29,435	2,943	10	2,943		15,941	17
18		Tile Floors in Tub Room	1994		4,405	441	10	441		2,389	18
19		Thermocouple on Boiler	1995		2,550	255	10	255		1,360	19
20		New Pump on Boiler System	1995		1,706	171	10	171		883	20
21		Air Conditioner Compressor	1995		1,668	167	10	167		849	21
22		Replace Fire Alarm	1995		3,743	374	10	374		1,901	22
23		Landscaping	1995		15,000	1,500	10	1,500		7,625	23
24		Counter Top	1995		527	53	10	53		291	24
25		New Door Frame Installed	1995		959	96	10	96		448	25
26		Rebuild Corner of Building	1996		2,000	200	10	200		850	26
27		Install Two Bell - Strobes	1996		888	89	10	89		378	27
28		Replace Relay & Timer on Generator	1996		1,325	132	10	132		528	28
29		Rebuild Commercial Water Softener	1996		1,880	188	10	188		893	29
30		Replace 3/4 H.P. Motor, Thermocoupler	1996		920	92	10	92		368	30
31		Replace Boiler Pumps and Bearing Assembly	1997		640	64	10	64		219	31
32		Install 3/4 H.P. Motor-Boiler	1997		725	72	10	72		234	32
33		Replace Circulating Pump, Bearings	1997		743	74	10	74		241	33
34		Twenty New Water Faucets	1997		2,296	230	10	230		728	34
35		Vinyl Floor Tile-Resident Room	1997		690	69	10	69		213	35
36		TOTAL (lines 4 thru 35)			\$ 97,413	\$ 9,739		\$ 9,739	\$	\$ 53,067	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.

Facility Name & ID Number Exceptional Care & Training Center# 0035477

Report Period Beginning:

07/01/99

Ending:

06/30/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		Reseal Parking Area	1997		2,845	285	10	285		879	9
10		Air Conditioning Condenser Unit	1997		1,650	165	10	165		468	10
11		Install Conduit	1997		913	91	10	91		250	11
12		Outlets & Wiring	1997		522	52	10	52		138	12
13		Kitchen Fire Suppression System	1998		767	77	10	77		186	13
14		Smoke Detectors	1998		621	62	10	62		150	14
15		Install Pipe & Wire	1998		995	99	10	99		231	15
16		Smoke Detectors	1998		1,644	165	10	165		386	16
17		Tank Replacement - PIPECO	1998		9,890	495	20	495		907	17
18		Generator and Transfer Switch Changeover	1998		2,746	275	10	275		504	18
19		Replace Tubes on Boiler, Galv. Pipes on Water Line	1998		1,690	169	10	169		282	19
20		Installed Boiler Control and Switch for Light	1998		709	71	10	71		124	20
21		Replace Faulty Smoke Detectors, Installed Batteries	1998		973	97	10	97		170	21
22		Installed Tile on Walls & in Staircase (New Addition)	1998		4,495	450	10	450		712	22
23		Two Hot Water Tanks Installed	1999		7,119	712	10	712		949	23
24		Installation Heavier Electric Service for Dishwasher	1999		1,651	165	10	165		220	24
25		Install New Cooling System Laundry / Kitchen	2000		4,650	116	20	116		116	25
26		Plaster & Drywall existing walls in Residents Rooms	2000		800	33	10	33		33	26
27		Install New Tile in Dinning Area & Two Classrooms	2000		4,770	80	15	80		80	27
28		Installed New Thermocouple on West Boiler	2000		353	9	10	9		9	28
29		Replace Thermocouple on West Boiler	2000		140	3	10	3		3	29
30		Replace Thermocouple on Inducer Fan	2000		215	5	10	5		5	30
31		Rebuilt two hopper foot valves / Installed Protectorelay	2000		1,430	36	10	36		36	31
32		Replace Coupler, Motor Mounts, Bearing assy, Impeller	2000		298	7	10	7		7	32
33		Labor to Install 120V Power to New Door Openers	2000		583	10	10	10		10	33
34		Replaced Bearing Assy on Hot Water Return Line	2000		518	9	10	9		9	34
35		Rounding				(2)		(2)		4	35
36		TOTAL (lines 4 thru 35)			\$ 52,987	\$ 3,736		\$ 3,736	\$	\$ 6,868	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.

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	
37	Purchased in Prior Years	\$ 71,763	\$ 11,455	\$ 11,455	\$		\$ 43,049	37
38	Current Year Purchases	24,426	1,701	1,701			1,701	38
39	Fully Depreciated Assets	337,667	4,016	4,016			337,667	39
40	Home Office Allocation		80	80				40
41	TOTALS	\$ 433,856	\$ 17,252	\$ 17,252	\$		\$ 382,417	41

D. Vehicle Depreciation (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	
42	Patient Transportation	Van Renovation	1991	\$ 5,840	\$	\$	\$	3	\$ 5,840	42
43	Patient Transportation	1995 Ford Van	1998	2,071	414	414		5	656	43
44										44
45										45
46	TOTALS			\$ 7,911	\$ 414	\$ 414	\$		\$ 6,496	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 3,777,385	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 111,454	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 111,454	49**
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,558,591	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58	Feasibility on New Parking Lot	\$ 203	58
59			59
60			60
61		\$ 203	61

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:
 Beginning _____
 Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2001</u>	\$ _____
13.	<u>/2002</u>	\$ _____
14.	<u>/2003</u>	\$ _____

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 NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? YES NO
 16. Rental Amount for movable equipment: \$ 4,073 Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE <u>47</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u>80</u></p>
---	--	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)	1,516	1,894		3,410
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)	2,580	3,224		5,804
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$ 4,096	\$ 5,118	\$	\$ 9,214
10	SUM OF line 9, col. 1 and 2 (e)	\$ 9,214			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	4
2. From other facilities (f)	
TOTAL TRAINED	9

- (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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$		\$					\$	1
2	Licensed Speech and Language Development Therapist		hrs											2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist		hrs											4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy		# of prescrpts											9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify):													13
14	TOTAL			\$		\$		\$		\$			\$	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Exceptional Care & Training Center

0035477

Report Period Beginning: 07/01/99

Ending:

06/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/00

(last day of reporting year)

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	\$ 800	\$	1
2 Cash-Patient Deposits	60,453		2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance 1,300)	730,108		3
4 Supply Inventory (priced at Cost)	8,536		4
5 Short-Term Investments			5
6 Prepaid Insurance	(20,285)		6
7 Other Prepaid Expenses	15,620		7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify): Due from Corporate Office	4,934,937		9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,730,169	\$	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	2,921,533		14
15 Leasehold Improvements, at Historical Cost			15
16 Equipment, at Historical Cost	441,767		16
17 Accumulated Depreciation (book methods)	(1,558,591)		17
18 Deferred Charges	299,941		18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds	2,473		21
22 Other Long-Term Assets (specify):	504,823		22
23 Other(specify): Goodwill	603,745		23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,629,776	\$	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,359,945	\$	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 47,822	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	60,453		28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	101,134		30
31 Accrued Taxes Payable (excluding real estate taxes)	2,733		31
32 Accrued Real Estate Taxes(Sch.IX-B)			32
33 Accrued Interest Payable	30,055		33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36			36
37			37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 242,197	\$	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable	4,960,000		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)	\$ 4,960,000	\$	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,202,197	\$	46
47 TOTAL EQUITY(page 18, line 24)	\$ 4,157,748	\$	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,359,945	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,766,241	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,766,241	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	391,507	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)	\$ 391,507	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)	\$ 4,157,748	24 *

* This must agree with page 17, line 47.

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,141,785	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,141,785	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	Nurses Aide Training Reimbursements		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)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	30,799	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 30,799	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	479,315	28
28a	Miscellaneous Income	(62)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 479,253	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,651,837	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	619,342	31
32	Health Care	1,477,919	32
33	General Administration	926,722	33
B. Capital Expense			
34	Ownership	500,478	34
C. Ancillary Expense			
35	Special Cost Centers	496,125	35
36	Provider Participation Fee	239,744	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,260,330	40
41	Income before Income Taxes (line 30 minus line 40)**	391,507	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 391,507	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

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

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

Facility Name & ID Number Exceptional Care & Training Center# 0035477Report Period Beginning: 07/01/99Ending: 06/30/00

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	2,051	\$ 41,520	\$ 19.86	1
2	Assistant Director of Nursing				2
3	Registered Nurses	4,981	98,660	18.03	3
4	Licensed Practical Nurses	18,170	283,883	14.03	4
5	Nurse Aides & Orderlies	74,562	761,741	9.22	5
6	Nurse Aide Trainees	1,242	9,214	7.11	6
7	Licensed Therapist	810	14,377	16.05	7
8	Rehab/Therapy Aides				8
9	Activity Director	1,627	24,421	13.57	9
10	Activity Assistants	17,199	124,302	6.53	10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor	2,011	31,316	14.98	13
14	Head Cook	6,660	64,320	8.64	14
15	Cook Helpers/Assistants	4,902	40,388	7.28	15
16	Dishwashers				16
17	Maintenance Workers	4,559	60,417	11.79	17
18	Housekeepers	8,922	76,012	7.54	18
19	Laundry	10,554	97,240	8.32	19
20	Administrator	2,000	53,479	25.71	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	4,046	43,545	9.75	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	10,432	135,609	11.74	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) <u>Day Training</u>	33,007	348,298	9.37	33
34	TOTAL (lines 1 - 33)	207,735	\$ 2,308,742 *	\$ 10.01	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	96	\$ 2,856	1.3	35
36	Medical Director	104	12,700	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	288	1,800	10.3	39
40	Physical Therapy Consultant	26	1,531	10a.3	40
41	Occupational Therapy Consultant	23	1,395	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	428	16,258	10a.3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Dental Fees</u>	N/A	6,000	10.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	965	\$ 42,540		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	Nurse Aides	156	2,783	10.3	52
53	TOTAL (lines 50 - 52)	156	\$ 2,783		53

Facility Name & ID Number Exceptional Care & Training Center

0035477

Report Period Beginning:

07/01/99

Ending:

06/30/00

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. See Schedule XIX, Section F
- (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? N/A
- (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? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 38,318 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. N/A
- (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 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 239,744
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? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation. N/A
- 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. \$ N/A
- 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? N/A
- 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. \$ 31,749
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: PriceWaterhouseCoopers The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.