

Facility Name & ID Number Exceptional Care & Training Center

0035477 Report Period Beginning: 07/01/04 Ending: 06/30/05

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 08/19/04

	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)	84	30,415	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	79	TOTALS	84	30,415	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED	28,585	61	0	28,646	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,585	61		28,646	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.18%

D. How many bed-hold days during this year were paid by the Department? 193 (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 0 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: 06/30/05 Fiscal Year: 06/30/05

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

STATE OF ILLINOIS

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/04 Ending: 06/30/05

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	184,149	19,042	4,056	207,247	(31)	207,216	207,216			1
2	Food Purchase		123,431		123,431		123,431	123,431			2
3	Housekeeping	107,573	10,915		118,488		118,488	118,488			3
4	Laundry	128,703	15,636		144,339		144,339	144,339			4
5	Heat and Other Utilities			120,301	120,301		120,301	120,301			5
6	Maintenance	65,625	11,254	35,970	112,849		112,849	112,849			6
7	Other (specify):*										7
8	TOTAL General Services	486,050	180,278	160,327	826,655	(31)	826,624	826,624			8
B. Health Care and Programs											
9	Medical Director			12,600	12,600		12,600	12,600			9
10	Nursing and Medical Records	1,583,629	70,111	7,544	1,661,284	(6,497)	1,654,787	1,654,787			10
10a	Therapy	27,496		34,897	62,393	(64)	62,329	62,329			10a
11	Activities	203,012	3,984		206,996		206,996	206,996			11
12	Social Services										12
13	CNA Training					6,979	6,979	6,979			13
14	Program Transportation		1,145		1,145		1,145	1,145			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,814,137	75,240	55,041	1,944,418	418	1,944,836	1,944,836			16
C. General Administration											
17	Administrative	74,159		121,593	195,752	(117,136)	78,616	(4,613)	74,003		17
18	Directors Fees					6,377	6,377		6,377		18
19	Professional Services			377,654	377,654	41,765	419,419		419,419		19
20	Dues, Fees, Subscriptions & Promotions			11,135	11,135	183	11,318	(461)	10,857		20
21	Clerical & General Office Expenses	56,258	13,273	34,678	104,209	25,513	129,722		129,722		21
22	Employee Benefits & Payroll Taxes			561,302	561,302	1,852	563,154		563,154		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,634	7,634	957	8,591	(1,169)	7,422		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			38,487	38,487		38,487		38,487		26
27	Other (specify):* Bad Debt			1,490	1,490		1,490	(1,490)			27
28	TOTAL General Administration	130,417	13,273	1,153,973	1,297,663	(40,489)	1,257,174	(7,733)	1,249,441		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,430,604	268,791	1,369,341	4,068,736	(40,102)	4,028,634	(7,733)	4,020,901		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:

07/01/04

Ending:

06/30/05

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			142,050	142,050	25	142,075		142,075			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			346,133	346,133	40,283	386,416	(24,961)	361,455			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			162	162		162		162			35
36	Other (specify):* Amortization			31,471	31,471		31,471	(20,759)	10,712			36
37	TOTAL Ownership			519,816	519,816	40,308	560,124	(45,720)	514,404			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			285,872	285,872		285,872		285,872			42
43	Other (specify):* Day Training	714,954	14,263	58,362	787,579	(206)	787,373		787,373			43
44	TOTAL Special Cost Centers	714,954	14,263	344,234	1,073,451	(206)	1,073,245		1,073,245			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,145,558	283,054	2,233,391	5,662,003		5,662,003	(53,453)	5,608,550			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: **07/01/04**

Ending: **06/30/05**

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	(24,961)	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	(461)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,490)	27		24
25	Fund Raising, Advertising and Promotional				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	(21,928)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (48,840)		\$	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)	(4,613)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (4,613)		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (53,453)		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.		X	\$		38
39		X		SNF/PED		39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Exceptional Care & Training Center

ID# 0035477

Report Period Beginning: 07/01/04

Ending: 06/30/05

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Goodwill	\$ (20,759)	36	1
2	Non-Allowable Travel	(1,169)	24	2
3				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
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	(21,928)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

07/01/04

Ending:

06/30/05

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	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	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(4,613)	0	0	0	0	0	0	0	0	0	(4,613)	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	(461)	0	0	0	0	0	0	0	0	0	0	(461)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	(1,169)	0	0	0	0	0	0	0	0	0	0	(1,169)	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):*	(1,490)	0	0	0	0	0	0	0	0	0	0	(1,490)	27
28	TOTAL General Administration	(3,120)	(4,613)	0	0	0	0	0	0	0	0	0	(7,733)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,120)	(4,613)	0	0	0	0	0	0	0	0	0	(7,733)	29

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Swann Special Care Center	Champaign			
		Walter Lawson Children's Home	Loves Park			
		Vernon Manor Children's Home	Wabash, Indiana			
		Richland Bean-Blossom HCC	Ellettsville, Indiana			
		Hanover Nursing Center	Hanover, Indiana			
		Clay County Nursing Center	Brazil, Indiana			
		Randolph Nursing Home	Winchester, Indiana			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Corporate Expense	\$ 121,593	Hoosier Care, Inc.	100.00%	\$ 116,980	\$ (4,613)	1
2	V							2
3	V			Note: See Schedule VIII of allocation of cost per column 7.				3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 121,593			\$ 116,980	\$ * (4,613)	14

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

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/04 Ending: 06/30/05

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	7,847			Director Fees	\$ 1,275	18.8	1
2	Stephen Wood	Director	Board Meetings	0.00	7,847			Director Fees	1,275	18.8	2
3	John Gillmor	Director	Board Meetings	0.00	7,848			Director Fees	1,275	18.8	3
4	John Foos	Director	Board Meetings	0.00	7,847			Director Fees	1,276	18.8	4
5	Michael Conn	Director	Board Meetings	0.00	7,847			Director Fees	1,276	18.8	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 6,377		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: 07/01/04 Ending: 06/30/05

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, KY 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	10	Nursing / Medical Records	Revenue	44,199,820	8	\$ 0	\$ 6,179,789	\$ 0	1
2	18	Director's Fees	Revenue	44,199,820	8	45,613	6,179,789	6,377	2
3	19	Professional Fees	Revenue	44,199,820	8	298,719	6,179,789	41,765	3
4	20	Fees,Subscription & Promotion	Revenue	44,199,820	8	1,310	6,179,789	183	4
5	21	Clerical & General Office Exp.	Revenue	44,199,820	8	182,653	6,179,789	25,538	5
6	22	Emp. Benefits & Payroll Tax	Revenue	44,199,820	8	13,248	6,179,789	1,852	6
7	24	Travel & Seminar	Revenue	44,199,820	8	6,848	6,179,789	957	7
8	30	Depreciation	Revenue	44,199,820	8	182	6,179,789	25	8
9	32	Interest Expense	Revenue	44,199,820	8	288,114	6,179,789	40,283	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 836,687	\$		\$ 116,980	25

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/04 Ending: 06/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	A. Directly Facility Related																			
	Long-Term																			
1	City of Sterling Bonds - 1999A		X	Purchase of Facility	Varies	7/8/99	\$ 4,775,000	\$ 4,540,000	6/1/2034	7.1250	\$ 325,702	1								
2	City of Sterling Bonds - 1999B		X	Purchase of Facility	Varies	7/8/99	220,000	190,000	6/2/2019	10.5000	20,431	2								
3												3								
4												4								
5												5								
	Working Capital																			
6	Corporate Allocation										40,283	6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 4,995,000	\$ 4,730,000			\$ 386,416	9								
	B. Non-Facility Related*																			
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 4,995,000	\$ 4,730,000			\$ 386,416	15								

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

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Exceptional Care & Training Center COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0035477

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Exceptional Care & Training Center# 0035477 Report Period Beginning:07/01/04 Ending:06/30/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,176 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, CNA 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</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:

07/01/04

Ending:

06/30/05**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 BHF 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	\$ 58,000	10-35	\$ 58,000	\$	\$ 1,227,166	4
5	15			1991	358,311	11,944	30	11,944		167,767	5
6	5			2004							6
7											7
8											8
	Improvement Type**										
9	Boiler Repair		1990		964		10			964	9
10	Water Unit		1991		8,780		10			8,780	10
11	PA System		1991		696		10			696	11
12	Building Addition - Drywall		1991		403		10			403	12
13	Closet Curtain Track		1991		650		10			650	13
14	Door		1991		1,614		10			1,614	14
15	Boiler Repair		1992		6,180		10			6,180	15
16	Storm Windows		1992		907		10			907	16
17	Boiler Tubes		1992		7,147		10			7,147	17
18	Roof		1992		11,118		10			11,118	18
19	Kitchen Tile		1992		3,660		10			3,660	19
20	Heating & Cooling Unit		1992		7,757		10			7,757	20
21	Shed		1992		1,678		10			1,678	21
22	Gate & Fence Scars		1992		4,038		10			4,038	22
23	Landscaping		1992		2,398		10			2,398	23
24	Drain Replacement		1992		1,576		10			1,576	24
25	Black Top		1992		575		10			575	25
26	Lighi Fixtures		1992		3,743		10			3,743	26
27	Building Renovation		1993		139	5	30	5		64	27
28	Painting - Laundry		1993		351		10			351	28
29	Building Renovation		1993		7,106		10			7,106	29
30	Painting - Laundry		1993		262		10			262	30
31	Parking Lot		1993		1,800		10			1,800	31
32	Tile Installation		1993		1,020		10			1,020	32
33	Electrical Work		1993		3,255		10			3,255	33
34	Pipe Installation - Laundry		1993		156		10			156	34
35	Water Heater Renovation		1993		849		10			849	35
36	Final Payment - Laundry		1993		1,030		10			1,030	36

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

See Page 12A, Line 70 for total

**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:

07/01/04

Ending:

06/30/05**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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Replace Relay in Panel	1993	\$ 1,150	\$	10	\$	\$	\$ 1,150	37
38	Install New Sewer Lines	1993	4,105		10			4,105	38
39	New Water Main	1993	12,204		10			12,204	39
40	Replace Parts on Sump Pumps	1994	4,034		10			4,034	40
41	Installed Back Flow Preventor	1994	1,053		10			1,053	41
42	Large Toilet Support, Back Stop	1994	923	26	10	26		923	42
43	Deck	1994	814	31	10	31		814	43
44	New Roof	1994	29,435	1,722	10	1,722		29,435	44
45	Tile Floors in Tub Room	1994	4,405	252	10	252		4,405	45
46	Thermocouple on Boiler	1995	2,550	170	10	170		2,550	46
47	New Pump on Boiler System	1995	1,706	139	10	139		1,706	47
48	Air Conditioner Compressor	1995	1,668	151	10	151		1,668	48
49	Replace Fire Alarm	1995	3,743	346	10	346		3,743	49
50	Landscaping	1995	15,000	1,375	10	1,375		15,000	50
51	Counter Top	1995	527	24	10	24		527	51
52	New Door Frame Installed	1995	959	96	10	96		928	52
53	Rebuild Corner of Building	1996	2,000	200	10	200		1,850	53
54	Install Two Bell - Strobes	1996	888	89	10	89		823	54
55	Replace Relay & Timer on Generator	1996	1,325	132	10	132		1,188	55
56	Rebuild Commercial Water Softener	1996	1,880	188	10	188		1,833	56
57	Replace 3/4 H.P. Motor, Thermocoupler	1996	920	92	10	92		828	57
58	Replace Boiler Pumps and Bearing Assembly	1997	640	64	10	64		539	58
59	Install 3/4 H.P. Motor-Boiler	1997	725	72	10	72		594	59
60	Replace Circulating Pump, Bearings	1997	743	74	10	74		611	60
61	Twenty New Water Faucets	1997	2,296	230	10	230		1,878	61
62	Vinyl Floor Tile-Resident Room	1997	690	69	10	69		558	62
63	Reseal Parking Area	1997	2,845	285	10	285		2,304	63
64	Air Conditioning Condenser Unit	1997	1,650	165	10	165		1,293	64
65	Install Conduit	1997	913	91	10	91		705	65
66	Outlets & Wiring	1997	522	52	10	52		398	66
67	Kitchen Fire Suppression System	1998	767	77	10	77		571	67
68	Smoke Detectors	1998	621	62	10	62		460	68
69	Install Pipe & Wire	1998	995	99	10	99		726	69
70	TOTAL (lines 4 thru 69)		\$ 2,876,859	\$ 76,322		\$ 76,322	\$	\$ 1,576,114	70

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

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

Report Period Beginning:

07/01/04

Ending:

06/30/05**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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 2,876,859	\$ 76,322		\$ 76,322		\$ 1,576,114		1
2	Smoke Detectors	1998 1,644	165	10	165		1,211		2
3	Tank Replacement - PIPECO	1998 9,890	495	20	495		3,382		3
4	Generator and Transfer Switch Changeover	1998 2,746	275	10	275		1,879		4
5	Replace Tubes on Boiler, Galv. Pipes on Water Line	1998 1,690	169	10	169		1,127		5
6	Installed Boiler Control and Switch for Light	1998 709	71	10	71		479		6
7	Replace Faulty Smoke Detectors, Installed Batteries	1998 973	97	10	97		655		7
8	Installed Tile on Walls & in Staircase (New Addition)	1998 4,495	450	10	450		2,962		8
9	Two Hot Water Tanks Installed	1999 7,119	712	10	712		4,509		9
10	Installation Heavier Electric Service for Dishwasher	1999 1,651	165	10	165		1,045		10
11	Install New Cooling System Laundry / Kitchen	2000 4,650	233	20	233		1,281		11
12	Plaster & Drywall existing walls in Residents Rooms	2000 800	80	10	80		433		12
13	Install New Tile in Dimming Area & Two Classrooms	2000 4,770	318	15	318		1,670		13
14	Installed New Thermocouple on West Boiler	2000 353	35	10	35		184		14
15	Replace Thermocouple on West Boiler	2000 140	14	10	14		73		15
16	Replace Thermocouple on Inducer Fan	2000 215	21	10	21		110		16
17	Rebuilt two hopper foot valves / Installed Protectorelay	2000 1,430	143	10	143		751		17
18	Replace Coupler, Motor Mounts, Bearing assy, Impeller	2000 298	30	10	30		157		18
19	Labor to Install 120V Power to New Door Openers	2000 583	58	10	58		300		19
20	Replaced Bearing Assy on Hot Water Return Line	2000 518	52	10	52		269		20
21	Indicator Lamps & Voltage	2000 1,525	153	10	153		726		21
22	Replace Heat Exchanger	2001 962	96	10	96		432		22
23	Replace Heat Exchanger	2001 962	96	10	96		424		23
24	Replace Draft Inducer	2001 1,414	141	10	141		611		24
25	Replace Pipe	2001 530	53	10	53		230		25
26	Replace Clinical Sink	2001 2,304	154	15	154		654		26
27	Furnish & Install Awning	2001 2,771	185	15	185		786		27
28	Labor & Mat-Breaker Panel	2001 3,930	262	15	262		1,113		28
29	Install Thermo Coupler	2001 944	94	10	94		392		29
30	Install Electric For Dishwasher	2001 820	55	15	55		229		30
31	Reroof Facility and Garage	2001 13,960	558	25	558		2,325		31
32	Lusterboard Sign	2001 515	103	5	103		421		32
33	Excavation of New Parking	2001 12,415	621	20	621		2,587		33
34	TOTAL (lines 1 thru 33)	\$ 2,964,585	\$ 82,476		\$ 82,476		\$ 1,609,521		34

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

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

Report Period Beginning:

07/01/04

Ending:

06/30/05**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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward	\$ 2,964,585	\$ 82,476		\$ 82,476	\$	\$ 1,609,521		1
2	Renovation Installment	2001 63,363	12,673	5	12,673		55,972		2
3	Concrete for Canapy & Add.	2001 2,592	519	5	519		2,249		3
4	Reconfigure Changing area	2001 3,393	679	5	679		2,546		4
5	Refund Electrical Panel	2001 (975)	(195)	5	(195)		(780)		5
6	Install Water Heater	2001 3,341	223	15	223		892		6
7	Conduit & Wiring for Door Holders	2001 1,982	132	15	132		528		7
8	Air Conditioning in Lobby-Motor Replacement	2001 349	35	10	35		137		8
9	East Tub Room Fan-Motor Replacement	2001 213	21	10	21		83		9
10	Drvrer Vent Replacement	2001 319	32	10	32		125		10
11	Reconfigure Water Heater Room	2001 1,860	124	15	124		475		11
12	Walkway	2001 4,120	275	15	275		1,077		12
13	Hand Railing on Stairs to Upper Parking Lot	2002 2,130	142	15	142		461		13
14	Privacy Fence	2002 2,550	255	10	255		786		14
15	Install Temp Control Cartridge-Boiler	2002 537	36	15	36		126		15
16	Internet Set Up Wiring, Cable	2002 3,061	204	10	204		697		16
17	Motor Boiler	2002 763	76	10	76		253		17
18	Replace Hallow Metal Door	2002 1,665	111	15	111		342		18
19	Shutters	2002 820	82	10	82		253		19
20	Storm Window Project	2002 8,937	447	20	447		1,378		20
21	Replace Breaker, Ballasts	2002 555	111	5	111		388		21
22	Tenant Allowance to Offset Fix-up Costs	2002 (5,000)	(1,000)	5	(1,000)		(3,500)		22
23	New Motor on Boiler	2002 962	96	10	96		288		23
24	Installed Hospital Grade Outlet	2002 2,256	226	10	226		659		24
25	Wiring for New Time Clock	2003 634	63	10	63		142		25
26	Motor & Coupler / Circular	2003 835	83	10	83		187		26
27	Side Screens on DT Awning	2003 738	148	5	148		345		27
28	Anne's Landscaping	2004 590	59	10	59		69		28
29	Parking Lot Renovation	2004 3,049	254	10	254		254		29
30	Parking Lot Renovation	2004 450	38	10	38		38		30
31	Fire & Electric System (Part of 298)	2004 435	57	7	57		57		31
32	New Electrical System (Multi Purpose)	2004 6,637	790	7	790		790		32
33	Conduit and Wire Hookup	2004 965	56	10	56		56		33
34	TOTAL (lines 1 thru 33)	\$ 3,078,711	\$ 99,328		\$ 99,328	\$	\$ 1,676,894		34

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

STATE OF ILLINOIS

Facility Name & ID Number Exceptional Care & Training Center

0035477

Report Period Beginning:

07/01/04

Ending:

06/30/05

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward	\$ 3,078,711	\$ 99,328		\$ 99,328	\$	\$ 1,676,894		1
2	34 Heat / Smoke Detectors	2004 2,800	233	7	233		233		2
3	Commerical Disposal	2005 551	39	7	39		39		3
4	18 Kickplates	2005 2,215	92	10	92		92		4
5	Hollow Metal Door	2005 945	5	15	5		5		5
6	Day Training Addition	2005 346,465	9,624	30	9,624		9,624		6
7	Rounding	(1)	(3)		(3)		(6)		7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,431,686	\$ 109,318		\$ 109,318	\$	\$ 1,686,881		34

**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	
71	Purchased in Prior Years	\$ 125,435	\$ 19,373	\$ 19,373	\$		\$ 72,557	71
72	Current Year Purchases	14,578	1,259	1,259			1,259	72
73	Fully Depreciated Assets	402,329	719	719			402,329	73
74	Corporate Allocation		25	25				74
75	TOTALS	\$ 542,342	\$ 21,376	\$ 21,376	\$		\$ 476,145	75

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	
76	Patient Transportation	1995 Ford Van	1998	\$ 2,071	\$	\$	\$		\$ 2,071	76
77	Patient Transportation	1985 GMC Bus	2000	26,150	5,230	5,230			24,842	77
78	Patient Transportation	2002 Van	2002	30,758	6,151	6,151			18,968	78
79										79
80	TOTALS			\$ 58,979	\$ 11,381	\$ 11,381	\$		\$ 45,881	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,447,092	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 142,075	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 142,075	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,208,907	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		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								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>/2006</u>	\$ _____
13.	<u>/2007</u>	\$ _____
14.	<u>/2008</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: \$ 162 Description: Ricoh Scanner

(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 CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><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 CNA <u>50</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 CNA <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		99		99
3	Classroom Wages (a)	350	1,750		2,100
4	Clinical Wages (b)	280	2,800		3,080
5	In-House Trainer Wages (c)		1,700		1,700
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 630	\$ 6,349	\$	\$ 6,979
10	SUM OF line 9, col. 1 and 2 (e)	\$ 630			

- (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.

C. CONTRACTUAL INCOME

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

\$ N/A

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	6

- (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.)

	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 prescripts											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 CNAs, 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: 07/01/04

Ending:

06/30/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/05

(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	\$ 1,040	\$	1
2	Cash-Patient Deposits	61,693		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (1,690))	956,586		3
4	Supply Inventory (priced at Cost)	14,900		4
5	Short-Term Investments			5
6	Prepaid Insurance	24,882		6
7	Other Prepaid Expenses	7,100		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Corporate	8,635,232		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 9,701,433	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	414,085		13
14	Buildings, at Historical Cost	3,431,686		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	601,321		16
17	Accumulated Depreciation (book methods)	(2,208,907)		17
18	Deferred Charges	264,967		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	425,331		22
23	Other(specify): Goodwill	499,950		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,428,433	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 13,129,866	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 69,400	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	61,693		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	197,734		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,800		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	28,619		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)	\$ 364,246	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,730,000		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)	\$ 4,730,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,094,246	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 8,035,620	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 13,129,866	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,476,157	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,476,157	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	559,463	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)	\$ 559,463	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)	\$ 8,035,620	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	\$ 4,778,491	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,778,491	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	6,370	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)	\$ 6,370	23
D. Non-Operating Revenue			
24	Contributions	2,088	24
25	Interest and Other Investment Income***	24,961	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 27,049	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>DMH Day Training</u>	1,409,556	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,409,556	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,221,466	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	826,655	31
32	Health Care	1,944,418	32
33	General Administration	1,297,663	33
B. Capital Expense			
34	Ownership	519,816	34
C. Ancillary Expense			
35	Special Cost Centers	787,579	35
36	Provider Participation Fee	285,872	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,662,003	40
41	Income before Income Taxes (line 30 minus line 40)**	559,463	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 559,463	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**

0035477

Report Period Beginning: 07/01/04

Ending:

06/30/05

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,706	\$ 56,942	\$ 33.38	1
2	Assistant Director of Nursing				2
3	Registered Nurses	4,402	110,006	22.29	3
4	Licensed Practical Nurses	21,374	430,905	18.24	4
5	CNAs & Orderlies	89,274	985,776	9.97	5
6	CNA Trainees				6
7	Licensed Therapist	1,457	27,496	16.54	7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants	21,613	203,012	8.52	10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	14,570	184,149	11.32	15
16	Dishwashers				16
17	Maintenance Workers	3,885	65,625	14.79	17
18	Housekeepers	10,677	107,573	9.11	18
19	Laundry	11,370	128,703	10.04	19
20	Administrator	1,895	74,159	39.13	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	3,747	56,258	13.25	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) <u>Day Training</u>	55,545	714,954	11.51	33
34	TOTAL (lines 1 - 33)	241,515	\$ 3,145,558 *	\$ 11.73	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	130	\$ 4,056	1.3	35
36	Medical Director	96	12,600	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	N/A	1,650	10.3	39
40	Physical Therapy Consultant	47	2,640	10a.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	505	22,600	10a.3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Dental Fees</u>	N/A	5,894	10.3	46
47	<u>Other Plant Operations</u>	N/A	16,430	6.3	47
48	<u>Other Administrative & General</u>	21	636	21.3	48
49	TOTAL (lines 35 - 48)	799	\$ 66,506		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

Facility Name & ID Number Exceptional Care & Training Center

0035477

Report Period Beginning: 07/01/04

Ending: 06/30/05

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. \$ 4,925 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 during this cost report period. \$ 285,872
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, 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? Yes - Offset
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. \$ 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. \$ 47,554
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Reznick Group 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.