

Facility Name & ID Number Exceptional Care & Training Center

0035477 Report Period Beginning: 7/1/05 Ending: 6/30/06

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	84	Skilled Pediatric (SNF/PED)	84	30,660	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	84	TOTALS	84	30,660	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED	28,675	0	0	28,675
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	28,675			28,675

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.53%

D. How many bed-hold days during this year were paid by the Department? 206 (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

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/06 Fiscal Year: 6/30/06

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

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/05 Ending: 6/30/06

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	189,280	24,744	6,987	221,011	5,046	226,057		226,057		1
2	Food Purchase		134,456		134,456		134,456		134,456		2
3	Housekeeping	111,003	(3)		111,000		111,000		111,000		3
4	Laundry	130,788	37,622		168,410		168,410		168,410		4
5	Heat and Other Utilities			135,770	135,770		135,770		135,770		5
6	Maintenance	64,705	9,519	44,915	119,139	497	119,636		119,636		6
7	Other (specify):*										7
8	TOTAL General Services	495,776	206,338	187,672	889,786	5,543	895,329		895,329		8
	B. Health Care and Programs										
9	Medical Director			12,600	12,600		12,600		12,600		9
10	Nursing and Medical Records	1,655,938	87,526	12,498	1,755,962	2,031	1,757,993		1,757,993		10
10a	Therapy	18,809		26,049	44,858		44,858		44,858		10a
11	Activities	192,662	2,427	70	195,159		195,159		195,159		11
12	Social Services		256	134	390	(134)	256		256		12
13	CNA Training										13
14	Program Transportation		4,423	5,370	9,793		9,793		9,793		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,867,409	94,632	56,721	2,018,762	1,897	2,020,659		2,020,659		16
	C. General Administration										
17	Administrative	74,604		135,975	210,579	(138,416)	72,163	2,441	74,604		17
18	Directors Fees					5,333	5,333		5,333		18
19	Professional Services			390,726	390,726	50,762	441,488		441,488		19
20	Dues, Fees, Subscriptions & Promotions			18,876	18,876	94	18,970	(6,016)	12,954		20
21	Clerical & General Office Expenses	61,460	16,541	42,109	120,110	26,081	146,191		146,191		21
22	Employee Benefits & Payroll Taxes			572,217	572,217	2,165	574,382	(260)	574,122		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,637	10,637	723	11,360	(2,711)	8,649		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			37,524	37,524		37,524		37,524		26
27	Other (specify):* Bad Debt			5,547	5,547		5,547	(5,547)			27
28	TOTAL General Administration	136,064	16,541	1,213,611	1,366,216	(53,258)	1,312,958	(12,093)	1,300,865		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,499,249	317,511	1,458,004	4,274,764	(45,818)	4,228,946	(12,093)	4,216,853		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:

7/1/05

Ending:

6/30/06

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			135,128	135,128	26	135,154		135,154			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			342,621	342,621	45,792	388,413	(26,779)	361,634			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			914	914		914		914			35
36	Other (specify):* Amortization			29,896	29,896		29,896	(20,759)	9,137			36
37	TOTAL Ownership			508,559	508,559	45,818	554,377	(47,538)	506,839			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			286,615	286,615		286,615		286,615			42
43	Other (specify):* Day Training	725,959	5,298	56,694	787,951		787,951		787,951			43
44	TOTAL Special Cost Centers	725,959	5,298	343,309	1,074,566		1,074,566		1,074,566			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,225,208	322,809	2,309,872	5,857,889		5,857,889	(59,631)	5,798,258			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:

7/1/05

Ending:

6/30/06

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	(26,779)	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	(5,547)	27		24
25	Fund Raising, Advertising and Promotional	(5,555)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(23,730)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (62,072)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	2,441		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 2,441		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (59,631)		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: 7/1/05

Ending: 6/30/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Goodwill	\$ (20,759)	36	1
2	Non-Allowable Travel	(2,516)	24	2
3	Non-Allowable Seminar	(195)	24	3
4	Employee Benefits	(260)	22	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	(23,730)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

7/1/05

Ending:

6/30/06

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	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	2,441	0	0	0	0	0	0	0	0	0	2,441	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	(6,016)	0	0	0	0	0	0	0	0	0	0	(6,016)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(260)	0	0	0	0	0	0	0	0	0	0	(260)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,711)	0	0	0	0	0	0	0	0	0	0	(2,711)	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):*	(5,547)	0	0	0	0	0	0	0	0	0	0	(5,547)	27
28	TOTAL General Administration	(14,534)	2,441	0	0	0	0	0	0	0	0	0	(12,093)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(14,534)	2,441	0	0	0	0	0	0	0	0	0	(12,093)	29

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

7/1/05

Ending:

6/30/06

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(26,779)	0	0	0	0	0	0	0	0	0	0	(26,779)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(20,759)	0	0	0	0	0	0	0	0	0	0	(20,759)	36
37	TOTAL Ownership	(47,538)	0	0	0	0	0	0	0	0	0	0	(47,538)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(62,072)	2,441	0	(59,631)	45								

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 Corporate Expense	\$ 135,975	Hoosier Care, Inc.	100.00%	\$ 138,416	\$ 2,441	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		\$ 135,975			\$ 138,416	\$ * 2,441	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: 7/1/05 Ending: 6/30/06

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	6,316			Director Fees	\$ 1,067	18.8	1
2	Stephen Wood	Director	Board Meetings	0.00	6,316			Director Fees	1,067	18.8	2
3	John Gillmor	Director	Board Meetings	0.00	6,317			Director Fees	1,066	18.8	3
4	John Foos	Director	Board Meetings	0.00	6,317			Director Fees	1,066	18.8	4
5	Michael Conn	Director	Board Meetings	0.00	6,317			Director Fees	1,067	18.8	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 5,333		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:

7/1/05

Ending: 6/30/06

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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Revenue	43,523,659	8	\$ 34,932	\$ 0	6,287,658	\$ 5,046	1
2	10	Nursing / Medical Records	Revenue	43,523,659	8	14,059	0	6,287,658	2,031	2
3	18	Director's Fees	Revenue	43,523,659	8	36,916	0	6,287,658	5,333	3
4	19	Professional Fees	Revenue	43,523,659	8	351,378	0	6,287,658	50,762	4
5	20	Fees,Subscription & Promotion	Revenue	43,523,659	8	649	0	6,287,658	94	5
6	21	Clerical & General Office Exp.	Revenue	43,523,659	8	183,050	0	6,287,658	26,444	6
7	22	Emp. Benefits & Payroll Tax	Revenue	43,523,659	8	14,983	0	6,287,658	2,165	7
8	24	Travel & Seminar	Revenue	43,523,659	8	5,004	0	6,287,658	723	8
9	30	Depreciation	Revenue	43,523,659	8	182	0	6,287,658	26	9
10	32	Interest Expense	Revenue	43,523,659	8	316,973	0	6,287,658	45,792	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					\$ 958,126	\$		\$ 138,416	25

Facility Name & ID Number

Exceptional Care & Training Center

0035477

Report Period Beginning:

7/1/05

Ending:

6/30/06

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	\$ 4,490,000	6/1/2034	7.1250	\$ 322,656	1						
2	City of Sterling Bonds - 1999B		X	Purchase of Facility	Varies	7/8/99	220,000	185,000	6/2/2019	10.5000	19,965	2						
3												3						
4												4						
5												5						
Working Capital																		
6	Corporate Allocation										45,792	6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 4,995,000	\$ 4,675,000			\$ 388,413	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	\$ 4,675,000			\$ 388,413	15						

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.

\$ **1**

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

\$ **2**

3. Under or (over) accrual (line 2 minus line 1).

\$ **3**

4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **4**

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.

(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

\$ **5**

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

\$ **6**

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$ **7**

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	<u> </u>	8
	2002	<u> </u>	9
	2003	<u> </u>	10
	2004	<u> </u>	11
	2005	<u> </u>	12

Note: The facility became exempt from property taxes starting 1/1/96

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2005	\$ <u> </u>	13
14	PLUS APPEAL COST FROM LINE 5	\$ <u> </u>	14
15	LESS REFUND FROM LINE 6	\$ <u> </u>	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ <u> </u>	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 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 2005 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 2005.

(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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Exceptional Care & Training Center

0035477

Report Period Beginning:

7/1/05

Ending:

6/30/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,176 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	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:

7/1/05

Ending:

6/30/06**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	\$	\$ 1,285,166	4
5	15			1991	358,311	11,944	30	11,944		179,711	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	Light Fixtures			1992	3,743		10			3,743	26
27	Building Renovation			1993	139	5	30	5		69	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:

7/1/05

Ending:

6/30/06**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	<u>Replace Relay in Panel</u>	1993	\$ 1,150	\$	10	\$	\$	\$ 1,150	37
38	<u>Install New Sewer Lines</u>	1993	4,105		10			4,105	38
39	<u>New Water Main</u>	1993	12,204		10			12,204	39
40	<u>Replace Parts on Sump Pumps</u>	1994	4,034		10			4,034	40
41	<u>Installed Back Flow Preventor</u>	1994	1,053		10			1,053	41
42	<u>Large Toilet Support, Back Stop</u>	1994	923		10			923	42
43	<u>Deck</u>	1994	814		10			814	43
44	<u>New Roof</u>	1994	29,435		10			29,435	44
45	<u>Tile Floors in Tub Room</u>	1994	4,405		10			4,405	45
46	<u>Thermocouple on Boiler</u>	1995	2,550		10			2,550	46
47	<u>New Pump on Boiler System</u>	1995	1,706		10			1,706	47
48	<u>Air Conditioner Compressor</u>	1995	1,668		10			1,668	48
49	<u>Replace Fire Alarm</u>	1995	3,743		10			3,743	49
50	<u>Landscaping</u>	1995	15,000		10			15,000	50
51	<u>Counter Top</u>	1995	527		10			527	51
52	<u>New Door Frame Installed</u>	1995	959	31	10	31		959	52
53	<u>Rebuild Corner of Building</u>	1996	2,000	150	10	150		2,000	53
54	<u>Install Two Bell - Strobes</u>	1996	888	65	10	65		888	54
55	<u>Replace Relay & Timer on Generator</u>	1996	1,325	137	10	137		1,325	55
56	<u>Rebuild Commercial Water Softener</u>	1996	1,880	47	10	47		1,880	56
57	<u>Replace 3/4 H.P. Motor, Thermocoupler</u>	1996	920	92	10	92		920	57
58	<u>Replace Boiler Pumps and Bearing Assembly</u>	1997	640	64	10	64		603	58
59	<u>Install 3/4 H.P. Motor-Boiler</u>	1997	725	72	10	72		666	59
60	<u>Replace Circulating Pump, Bearings</u>	1997	743	74	10	74		685	60
61	<u>Twenty New Water Faucets</u>	1997	2,296	230	10	230		2,108	61
62	<u>Vinyl Floor Tile-Resident Room</u>	1997	690	69	10	69		627	62
63	<u>Reseal Parking Area</u>	1997	2,845	285	10	285		2,589	63
64	<u>Air Conditioning Condenser Unit</u>	1997	1,650	165	10	165		1,458	64
65	<u>Install Conduit</u>	1997	913	91	10	91		796	65
66	<u>Outlets & Wiring</u>	1997	522	52	10	52		450	66
67	<u>Kitchen Fire Suppression System</u>	1998	767	77	10	77		648	67
68	<u>Smoke Detectors</u>	1998	621	62	10	62		522	68
69	<u>Install Pipe & Wire</u>	1998	995	99	10	99		825	69
70	TOTAL (lines 4 thru 69)		\$ 2,876,859	\$ 71,811		\$ 71,811	\$	\$ 1,647,925	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:

7/1/05

Ending:

6/30/06**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	\$ 71,811		\$ 71,811	\$	\$ 1,647,925	1
2	Smoke Detectors	1998	1,644	165	10	165		1,376	2
3	Tank Replacement - PIPECO	1998	9,890	495	20	495		3,877	3
4	Generator and Transfer Switch Changeover	1998	2,746	275	10	275		2,154	4
5	Replace Tubes on Boiler, Galv. Pipes on Water Line	1998	1,690	169	10	169		1,296	5
6	Installed Boiler Control and Switch for Light	1998	709	71	10	71		550	6
7	Replace Faulty Smoke Detectors, Installed Batteries	1998	973	97	10	97		752	7
8	Installed Tile on Walls & in Staircase (New Addition)	1998	4,495	450	10	450		3,412	8
9	Two Hot Water Tanks Installed	1999	7,119	712	10	712		5,221	9
10	Installation Heavier Electric Service for Dishwasher	1999	1,651	165	10	165		1,210	10
11	Install New Cooling System Laundry / Kitchen	2000	4,650	233	20	233		1,514	11
12	Plaster & Drywall Existing Walls in Residents Rooms	2000	800	80	10	80		513	12
13	Install New Tile in Dining Area & Two Classrooms	2000	4,770	318	15	318		1,988	13
14	Installed New Thermocouple on West Boiler	2000	353	35	10	35		219	14
15	Replace Thermocouple on West Boiler	2000	140	14	10	14		87	15
16	Replace Thermocouple on Inducer Fan	2000	215	21	10	21		131	16
17	Rebuilt Two Hopper Foot Valves / Installed Protectorelay	2000	1,430	143	10	143		894	17
18	Replace Coupler, Motor Mounts, Bearing assy, Impeller	2000	298	30	10	30		187	18
19	Labor to Install 120V Power to New Door Openers	2000	583	58	10	58		358	19
20	Replaced Bearing Assy on Hot Water Return Line	2000	518	52	10	52		321	20
21	Indicator Lamps & Voltage	2000	1,525	153	10	153		879	21
22	Replace Heat Exchanger	2001	962	96	10	96		528	22
23	Replace Heat Exchanger	2001	962	96	10	96		520	23
24	Replace Draft Inducer	2001	1,414	141	10	141		752	24
25	Replace Pipe	2001	530	53	10	53		283	25
26	Replace Clinical Sink	2001	2,304	154	15	154		808	26
27	Furnish & Install Awning	2001	2,771	185	15	185		971	27
28	Labor & Mat-Breaker Panel	2001	3,930	262	15	262		1,375	28
29	Install Thermo Coupler	2001	944	94	10	94		486	29
30	Install Electric For Dishwasher	2001	820	55	15	55		284	30
31	Reroof Facility and Garage	2001	13,960	558	25	558		2,883	31
32	Lusterboard Sign	2001	515	94	5	94		515	32
33	Excavation of New Parking	2001	12,415	621	20	621		3,208	33
34	TOTAL (lines 1 thru 33)		\$ 2,964,585	\$ 77,956		\$ 77,956	\$	\$ 1,687,477	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:

7/1/05

Ending:

6/30/06**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	\$ 77,956		\$ 77,956	\$	\$ 1,687,477	1
2	Renovation Installment	2001	63,363	7,391	5	7,391		63,363	2
3	Concrete for Canapy & Add.	2001	2,592	343	5	343		2,592	3
4	Reconfigure Changing area	2001	3,393	679	5	679		3,225	4
5	Refund Electrical Panel	2001	(975)	(195)	5	(195)		(975)	5
6	Install Water Heater	2001	3,341	223	15	223		1,115	6
7	Conduit & Wiring for Door Holders	2001	1,982	132	15	132		660	7
8	Air Conditioning in Lobby-Motor Replacement	2001	349	35	10	35		172	8
9	East Tub Room Fan-Motor Replacement	2001	213	21	10	21		104	9
10	Dryer Vent Replacement	2001	319	32	10	32		157	10
11	Reconfigure Water Heater Room	2001	1,860	124	15	124		599	11
12	Walkway	2001	4,120	275	15	275		1,352	12
13	Hand Railing on Stairs to Upper Parking Lot	2002	2,130	142	15	142		603	13
14	Privacy Fence	2002	2,550	255	10	255		1,041	14
15	Install Temp Control Cartridge-Boiler	2002	537	36	15	36		162	15
16	Internet Set Up Wiring, Cable	2002	3,061	204	10	204		901	16
17	Motor Boiler	2002	763	76	10	76		329	17
18	Replace Hallow Metal Door	2002	1,665	111	15	111		453	18
19	Shutters	2002	820	82	10	82		335	19
20	Storm Window Project	2002	8,937	447	20	447		1,825	20
21	Replace Breaker, Ballasts	2002	555	111	5	111		499	21
22	Tennant Allowance to Offset Fix-up Costs	2002	(5,000)	(1,000)	5	(1,000)		(4,500)	22
23	New Motor on Boiler	2002	962	96	10	96		384	23
24	Installed Hospital Grade Outlet	2002	2,256	226	10	226		885	24
25	Wiring for New Time Clock	2003	634	63	10	63		205	25
26	Motor & Coupler / Circular	2003	835	83	10	83		270	26
27	Side Screens on DT Awning	2003	738	148	5	148		493	27
28	Anne's Landscaping	2004	590	59	10	59		128	28
29	Parking Lot Renovation	2004	3,049	305	10	305		559	29
30	Parking Lot Renovation	2004	450	7	10	7		45	30
31	Fire & Electric System (Part of 298)	2004	435	62	7	62		119	31
32	New Electrical System (Multi Purpose)	2004	6,637	948	7	948		1,738	32
33	Conduit and Wire Hookup	2004	965	97	10	97		153	33
34	TOTAL (lines 1 thru 33)		\$ 3,078,711	\$ 89,574		\$ 89,574	\$	\$ 1,766,468	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:

7/1/05

Ending:

6/30/06

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	\$ 89,574		\$ 89,574	\$	\$ 1,766,468	1
2	34 Heat / Smoke Detectors	2004	2,800	400	7	400		633	2
3	Commerical Disposal	2005	551	79	7	79		118	3
4	18 Kickplates	2005	2,215	222	10	222		314	4
5	Hollow Metal Door	2005	945	63	15	63		68	5
6	Day Training Addition	2005	346,465	11,549	30	11,549		21,173	6
7	3 Window A/C Units	2005	1,755	251	5	251		251	7
8	Compressor in Lobby - Replacement	2005	11,445	699	15	699		699	8
9	2 A/C Units	2005	1,170	139	7	139		139	9
10	Booster Pump / Shower Head - Replacement	2005	943	55	10	55		55	10
11	Hot Water Mixing Valve - Replacement	2005	1,168	78	10	78		78	11
12	Install Pull Station / Light / Speaker	2005	1,434	108	10	108		108	12
13	New Roof (down payment)	2006	15,987	533	10	533		533	13
14	Sprinkler System	2006	33,165		15				14
15	Water Heater	2006	4,717		10				15
16	3 A/C Units	2006	1,755		7				16
17	Rounding		(2)	(2)		(2)		(8)	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)		\$ 3,505,224	\$ 103,748		\$ 103,748	\$	\$ 1,790,629	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	\$ 111,160	\$ 17,244	\$ 17,244	\$		\$ 67,261	71
72	Current Year Purchases	34,434	3,425	3,425			3,425	72
73	Fully Depreciated Assets	429,317	3,189	3,189			429,317	73
74	Corporate Allocation		26	26				74
75	TOTALS	\$ 574,911	\$ 23,884	\$ 23,884	\$		\$ 500,003	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	1,308	1,308			26,150	77
78	Patient Transportation	2002 Van	2002	19,706	3,940	3,940			16,093	78
79	Patient Transportation	2002 Van	2002	11,803	2,274	2,274			9,089	79
80	TOTALS			\$ 59,730	\$ 7,522	\$ 7,522	\$		\$ 53,403	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)	\$ 4,553,950	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 135,154	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 135,154	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)	\$ 2,344,035	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

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: \$ 914 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

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. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* 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? <input type="checkbox"/> YES <input checked="" 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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# 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: 7/1/05

Ending:

6/30/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/06

(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	\$ 1,678	\$	1
2	Cash-Patient Deposits	59,496		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (1,598)	1,001,647		3
4	Supply Inventory (priced at cost)	12,726		4
5	Short-Term Investments			5
6	Prepaid Insurance	38,678		6
7	Other Prepaid Expenses	5,500		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from Corporate</u>	9,044,138		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 10,163,863	\$	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	3,505,224		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	634,641		16
17	Accumulated Depreciation (book methods)	(2,344,035)		17
18	Deferred Charges	255,830		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):	424,416		22
23	Other(specify): <u>Goodwill</u>	479,190		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,369,351	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 13,533,214	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 55,097	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	59,496		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	213,669		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,200		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	28,278		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)	\$ 362,740	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,675,000		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)	\$ 4,675,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,037,740	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 8,495,474	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 13,533,214	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,035,620	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,035,620	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	459,854	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)	\$ 459,854	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)	\$ 8,495,474	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	\$ 4,837,688	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,837,688	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		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	4,812	24
25	Interest and Other Investment Income***	26,779	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 31,591	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>DMH Day Training</u>	1,448,205	28
28a	<u>Miscellaneous Income</u>	260	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,448,465	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,317,744	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	889,786	31
32	Health Care	2,018,762	32
33	General Administration	1,366,216	33
	B. Capital Expense		
34	Ownership	508,559	34
	C. Ancillary Expense		
35	Special Cost Centers	787,951	35
36	Provider Participation Fee	286,615	36
	D. Other Expenses (specify):		
37	<u>Rounding</u>	1	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,857,890	40
41	Income before Income Taxes (line 30 minus line 40)**	459,854	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 459,854	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:

7/1/05

Ending:

6/30/06

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	1,978	1,978	\$ 57,080	\$ 28.86	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,854	6,327	140,414	22.19	3
4	Licensed Practical Nurses	22,329	24,586	450,832	18.34	4
5	CNAs & Orderlies	93,490	102,047	1,007,619	9.87	5
6	CNA Trainees					6
7	Licensed Therapist	963	1,053	18,809	17.86	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,087	2,452	38,807	15.83	9
10	Activity Assistants	18,718	20,224	153,855	7.61	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,034	2,250	42,697	18.98	13
14	Head Cook	5,667	6,395	68,501	10.71	14
15	Cook Helpers/Assistants	9,493	10,024	78,082	7.79	15
16	Dishwashers					16
17	Maintenance Workers	3,909	4,404	64,705	14.69	17
18	Housekeepers	11,381	12,453	111,003	8.91	18
19	Laundry	11,938	13,109	130,788	9.98	19
20	Administrator	1,909	1,909	74,604	39.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,965	4,371	61,450	14.06	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>	58,931	65,810	725,962	11.03	33
34	TOTAL (lines 1 - 33)	254,646	279,392	\$ 3,225,208 *	\$ 11.54	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	182	\$ 6,897	1.3	35
36	Medical Director	96	12,600	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant	50	3,612	10.3	38
39	Pharmacist Consultant	N/A	1,950	10.3	39
40	Physical Therapy Consultant	37	2,694	10a.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	344	23,355	10a.3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Dental Fees</u>	N/A	6,106	10.3	46
47	<u>Other Plant Operations</u>	N/A	22,376	6.3	47
48	<u>Other Administrative & General</u>	58	1,923	21.3	48
49	TOTAL (lines 35 - 48)	767	\$ 81,513		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:

7/1/05

Ending:

6/30/06**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. \$ 20,814 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 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. \$ 286,615
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. \$ 48,147
- (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? Yes
Attach invoices and a summary of services for all architect and appraisal fees