

		FOR BHF USE					

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

**I. IDPH License ID Number:** 0035477

**Facility Name:** Exceptional Care & Training Center

**Address:** 2601 Woodlawn Road Sterling 61081  
 Number City Zip Code

**County:** Whiteside

**Telephone Number:** (815) 626-8520 **Fax #** (815) 626-8075

**HFS ID Number:** 31-1262572

**Date of Initial License for Current Owners:** 08/15/89

**Type of Ownership:**

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> <u>501(c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

**In the event there are further questions about this report, please contact:**  
**Name:** James R. Johnson **Telephone Number:** (859) 255-0075

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/06 to 06/30/07 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

(Signed) \_\_\_\_\_ (Date) \_\_\_\_\_

**Officer or Administrator of Provider** (Type or Print Name) James R. Johnson

(Title) V.P. of Finance - Medical Rehabilitation Centers, Inc.

(Signed) See Compilation Report (Date) \_\_\_\_\_

**Paid Preparer** (Print Name and Title) Robert A. Thomas Partner

(Firm Name & Address) Thomas Healthcare Consulting, P.C. 11988 Fishers Crossing Dr., Suite 200, Fishers, IN 46038

(Telephone) (317) 577-0101 Fax # (317) 577-3389

MAIL TO: BUREAU OF HEALTH FINANCE  
 ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES  
 201 S. Grand Avenue East  
 Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care & Training Center

# 0035477 Report Period Beginning: 07/01/06 Ending: 06/30/07

**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 N/A

	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	29,356	31	0	29,387
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	29,356	31		29,387

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.85%

D. How many bed-hold days during this year were paid by the Department? 140 (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: 6/30/07 Fiscal Year: 06/30/07

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	189,091	16,755	5,967	211,813	3,583	215,396		215,396			1
2	Food Purchase		155,742		155,742		155,742		155,742			2
3	Housekeeping	100,788	1,707		102,495		102,495		102,495			3
4	Laundry	136,447	22,810		159,257		159,257		159,257			4
5	Heat and Other Utilities			140,930	140,930		140,930		140,930			5
6	Maintenance	56,300	11,128	50,651	118,079		118,079		118,079			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	<b>482,626</b>	<b>208,142</b>	<b>197,548</b>	<b>888,316</b>	<b>3,583</b>	<b>891,899</b>		<b>891,899</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director			23,100	23,100		23,100		23,100			9
10	Nursing and Medical Records	1,725,634	102,346	5,639	1,833,619	4,355	1,837,974		1,837,974			10
10a	Therapy	3,203		13,034	16,237		16,237		16,237			10a
11	Activities	196,627	2,807		199,434		199,434		199,434			11
12	Social Services											12
13	CNA Training		889		889		889		889			13
14	Program Transportation		5,503		5,503		5,503		5,503			14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>1,925,464</b>	<b>111,545</b>	<b>41,773</b>	<b>2,078,782</b>	<b>4,355</b>	<b>2,083,137</b>		<b>2,083,137</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	78,300		126,771	205,071	(136,436)	68,635	9,665	78,300			17
18	Directors Fees					6,350	6,350		6,350			18
19	Professional Services			402,236	402,236	50,330	452,566		452,566			19
20	Dues, Fees, Subscriptions & Promotions			16,118	16,118	232	16,350	(2,720)	13,630			20
21	Clerical & General Office Expenses	60,321	17,331	39,048	116,700	28,787	145,487	(110)	145,377			21
22	Employee Benefits & Payroll Taxes			573,885	573,885	3,726	577,611		577,611			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,091	7,091	138	7,229	(491)	6,738			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			38,092	38,092		38,092		38,092			26
27	Other (specify):* <b>Bad Debt</b>			5,127	5,127		5,127	(5,127)				27
28	<b>TOTAL General Administration</b>	<b>138,621</b>	<b>17,331</b>	<b>1,208,368</b>	<b>1,364,320</b>	<b>(46,873)</b>	<b>1,317,447</b>	<b>1,217</b>	<b>1,318,664</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,546,711</b>	<b>337,018</b>	<b>1,447,689</b>	<b>4,331,418</b>	<b>(38,935)</b>	<b>4,292,483</b>	<b>1,217</b>	<b>4,293,700</b>			<b>29</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

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: 07/01/06 Ending: 06/30/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			130,378	130,378	29	130,407		130,407		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			382,474	382,474	38,957	421,431	(74,238)	347,193		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			3,749	3,749	(51)	3,698		3,698		35
36	Other (specify):* <b>Amortization</b>			31,106	31,106		31,106	(21,969)	9,137		36
37	<b>TOTAL Ownership</b>			547,707	547,707	38,935	586,642	(96,207)	490,435		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
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			289,928	289,928		289,928		289,928		42
43	Other (specify):* <b>Day Training</b>	724,923	3,190	62,594	790,707		790,707		790,707		43
44	<b>TOTAL Special Cost Centers</b>	724,923	3,190	352,522	1,080,635		1,080,635		1,080,635		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,271,634	340,208	2,347,918	5,959,760		5,959,760	(94,990)	5,864,770		45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care & Training Center

# 0035477

Report Period Beginning: 07/01/06

Ending: 06/30/07

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(30,085)	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	(100)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(45)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,127)	27		24
25	Fund Raising, Advertising and Promotional	(2,620)	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	(66,678)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (104,655)		\$	30

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)	9,665		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 9,665		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (94,990)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Exceptional Care & Training Center

ID# 0035477

Report Period Beginning: 07/01/06

Ending: 06/30/07

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

07/01/06

Ending:

06/30/07**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)	
	<b>A. General Services</b>													
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	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	9,665	0	0	0	0	0	0	0	0	0	9,665	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	(2,720)	0	0	0	0	0	0	0	0	0	0	(2,720)	20
21	Clerical & General Office Expenses	(45)	0	0	0	0	0	0	0	0	0	0	(45)	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	0	0	0	0	0	0	0	0	0	0	0	0	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):*	(5,127)	0	0	0	0	0	0	0	0	0	0	(5,127)	27
28	<b>TOTAL General Administration</b>	(7,892)	9,665	0	0	0	0	0	0	0	0	0	1,773	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(7,892)	9,665	0	0	0	0	0	0	0	0	0	1,773	29

STATE OF ILLINOIS

Summary B

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

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	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	(30,085)	0	0	0	0	0	0	0	0	0	0	(30,085)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(30,085)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(30,085)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(37,977)</b>	<b>9,665</b>	<b>0</b>	<b>(28,312)</b>	<b>45</b>								

Facility Name & ID Number Exceptional Care & Training Center

# 0035477

Report Period Beginning:

07/01/06

Ending:

06/30/07

**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	\$ 126,771	Hoosier Care, Inc.	100.00%	\$ 136,436	\$ 9,665	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		\$ 126,771			\$ 136,436	\$ * 9,665	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

## 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	8,506			Director Fees	\$ 1,588	18.8	1
2	Stephen Wood	Director	Board Meetings	0.00	8,506			Director Fees	1,588	18.8	2
3	John Gillmor	Director	Board Meetings	0.00	8,506			Director Fees	1,587	18.8	3
4	John Foos	Director	Board Meetings	0.00	8,506			Director Fees	1,587	18.8	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 6,350		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care & Training Center

# 0035477

Report Period Beginning: 07/01/06

Ending: 06/30/07

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

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

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	41,622,539	8	\$ 22,782	\$ 0	6,546,365	\$ 3,583	1
2	10	Nursing / Medical Records	Revenue	41,622,539	8	27,688	0	6,546,365	4,355	2
3	18	Director's Fees	Revenue	41,622,539	8	40,374	0	6,546,365	6,350	3
4	19	Professional Fees	Revenue	41,622,539	8	320,007	0	6,546,365	50,330	4
5	20	Fees, Subscription & Promotion	Revenue	41,622,539	8	1,472	0	6,546,365	232	5
6	21	Clerical & General Office Exp.	Revenue	41,622,539	8	182,708	0	6,546,365	28,736	6
7	22	Emp. Benefits & Payroll Tax	Revenue	41,622,539	8	23,692	0	6,546,365	3,726	7
8	24	Travel & Seminar	Revenue	41,622,539	8	875	0	6,546,365	138	8
9	30	Depreciation	Revenue	41,622,539	8	182	0	6,546,365	29	9
10	32	Interest Expense	Revenue	41,622,539	8	247,694	0	6,546,365	38,957	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					\$ 867,474	\$		\$ 136,436	25

SEE ACCOUNTANTS' COMPILATION REPORT

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	City of Sterling Bonds - 1999A		X	Purchase of Facility	Varies	7/8/99	\$ 4,775,000	\$ 4,435,000	6/1/2034	7.1250	\$ 318,969	1								
2	City of Sterling Bonds - 1999B		X	Purchase of Facility	Varies	7/8/99	220,000	180,000	6/2/2019	10.5000	19,352	2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Corporate Allocation										38,957	6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>						\$ 4,995,000	\$ 4,615,000			\$ 377,278	9								
<b>B. Non-Facility Related*</b>																				
10	Debt Allocation		X	Purchase of Facility	Varies	7/8/99		1,042,054	Varies	Varies	44,153	10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	1,042,054			\$ 44,153	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 4,995,000	\$ 5,657,054			\$ 421,431	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* 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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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 2006 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 2006.

(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. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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:**

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	<b>TOTALS</b>	<b>63,598</b>		<b>\$ 414,085</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

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

Report Period Beginning:

**07/01/06**

Ending:

**06/30/07****XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	64		1989		\$ 2,334,000	\$ 58,000	10-35	\$ 58,000		\$ 1,343,166	4
5	15			1991	358,311	11,944	30	11,944		191,655	5
6	5			2004							6
7											7
8											8
<b>Improvement Type**</b>											
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		70	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.

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

**See Page 12A, Line 70 for total**

SEE ACCOUNTANTS' COMPILATION REPORT

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

Report Period Beginning:

07/01/06

Ending:

06/30/07**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		10			923	42
43	Deck	1994	814		10			814	43
44	New Roof	1994	29,435		10			29,435	44
45	Tile Floors in Tub Room	1994	4,405		10			4,405	45
46	Thermocouple on Boiler	1995	2,550		10			2,550	46
47	New Pump on Boiler System	1995	1,706		10			1,706	47
48	Air Conditioner Compressor	1995	1,668		10			1,668	48
49	Replace Fire Alarm	1995	3,743		10			3,743	49
50	Landscaping	1995	15,000		10			15,000	50
51	Counter Top	1995	527		10			527	51
52	New Door Frame Installed	1995	959		10			959	52
53	Rebuild Corner of Building	1996	2,000		10			2,000	53
54	Install Two Bell - Strobes	1996	888		10			888	54
55	Replace Relay & Timer on Generator	1996	1,325		10			1,325	55
56	Rebuild Commercial Water Softener	1996	1,880		10			1,880	56
57	Replace 3/4 H.P. Motor, Thermocoupler	1996	920		10			920	57
58	Replace Boiler Pumps and Bearing Assembly	1997	640	37	10	37		640	58
59	Install 3/4 H.P. Motor-Boiler	1997	725	54	10	54		725	59
60	Replace Circulating Pump, Bearings	1997	743	56	10	56		743	60
61	Twenty New Water Faucets	1997	2,296	191	10	191		2,296	61
62	Vinyl Floor Tile-Resident Room	1997	690	63	10	63		690	62
63	Reseal Parking Area	1997	2,845	261	10	261		2,845	63
64	Air Conditioning Condenser Unit	1997	1,650	165	10	165		1,623	64
65	Install Conduit	1997	913	91	10	91		890	65
66	Outlets & Wiring	1997	522	52	10	52		504	66
67	Kitchen Fire Suppression System	1998	767	77	10	77		722	67
68	Smoke Detectors	1998	621	62	10	62		584	68
69	Install Pipe & Wire	1998	995	100	10	100		929	69
70	TOTAL (lines 4 thru 69)		\$ 2,876,859	\$ 71,158		\$ 71,158	\$	\$ 1,719,084	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number    Exceptional Care &amp; Training Center

#    0035477

Report Period Beginning:

07/01/06

Ending:

06/30/07

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,876,859	\$ 71,158		\$ 71,158	\$	\$ 1,719,084	1
2	Smoke Detectors	1998	1,644	165	10	165		1,535	2
3	Tank Replacement - PIPECO	1998	9,890	495	20	495		4,368	3
4	Generator and Transfer Switch Changeover	1998	2,746	275	10	275		2,426	4
5	Replace Tubes on Boiler, Galv. Pipes on Water Line	1998	1,690	169	10	169		1,465	5
6	Installed Boiler Control and Switch for Light	1998	709	71	10	71		621	6
7	Replace Faulty Smoke Detectors, Installed Batteries	1998	973	97	10	97		851	7
8	Installed Tile on Walls & in Staircase (New Addition)	1998	4,495	450	10	450		3,858	8
9	Two Hot Water Tanks Installed	1999	7,119	712	10	712		5,933	9
10	Installation Heavier Electric Service for Dishwasher	1999	1,651	165	10	165		1,376	10
11	Install New Cooling System Laundry / Kitchen	2000	4,650	233	20	233		1,744	11
12	Plaster & Drywall Existing Walls in Residents Rooms	2000	800	80	10	80		593	12
13	Install New Tile in Dinning Area & Two Classrooms	2000	4,770	318	15	318		2,306	13
14	Installed New Thermocouple on West Boiler	2000	353	35	10	35		256	14
15	Replace Thermocouple on West Boiler	2000	140	14	10	14		101	15
16	Replace Thermocouple on Inducer Fan	2000	215	21	10	21		156	16
17	Rebuilt Two Hopper Foot Valves / Installed Protectorelay	2000	1,430	143	10	143		1,036	17
18	Replace Coupler, Motor Mounts, Bearing assy, Impeller	2000	298	30	10	30		216	18
19	Labor to Install 120V Power to New Door Openers	2000	583	58	10	58		418	19
20	Replaced Bearing Assy on Hot Water Return Line	2000	518	52	10	52		372	20
21	Indicator Lamps & Voltage	2000	1,525	153	10	153		1,030	21
22	Replace Heat Exchanger	2001	962	96	10	96		625	22
23	Replace Heat Exchanger	2001	962	96	10	96		617	23
24	Replace Draft Inducer	2001	1,414	141	10	141		896	24
25	Replace Pipe	2001	530	53	10	53		336	25
26	Replace Clinical Sink	2001	2,304	154	15	154		960	26
27	Furnish & Install Awning	2001	2,771	185	15	185		1,155	27
28	Labor & Mat-Breaker Panel	2001	3,930	262	15	262		1,637	28
29	Install Thermo Coupler	2001	944	94	10	94		582	29
30	Install Electric For Dishwasher	2001	820	55	15	55		337	30
31	Reroof Facility and Garage	2001	13,960	558	25	558		3,443	31
32	Lusterboard Sign	2001	515		5			515	32
33	Excavation of New Parking	2001	12,415	621	20	621		3,828	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,964,585	\$ 77,209		\$ 77,209	\$	\$ 1,764,676	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number    Exceptional Care &amp; Training Center

#    0035477

Report Period Beginning:

07/01/06

Ending:

06/30/07

**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 2,964,585	\$ 77,209		\$ 77,209	\$	\$ 1,764,676	1
2	Renovation Installment	2001	63,363		5			63,363	2
3	Concrete for Canapy & Add.	2001	2,592		5			2,592	3
4	Reconfigure Changing area	2001	3,393	170	5	170		3,393	4
5	Refund Electrical Panel	2001	(975)		5			(975)	5
6	Install Water Heater	2001	3,341	223	15	223		1,336	6
7	Conduit & Wiring for Door Holders	2001	1,982	132	15	132		793	7
8	Air Conditioning in Lobby-Motor Replacement	2001	349	35	10	35		206	8
9	East Tub Room Fan-Motor Replacement	2001	213	21	10	21		126	9
10	Dryer Vent Replacement	2001	319	32	10	32		189	10
11	Reconfigure Water Heater Room	2001	1,860	124	15	124		723	11
12	Walkway	2001	4,120	275	15	275		1,625	12
13	Hand Railing on Stairs to Upper Parking Lot	2002	2,130	142	15	142		745	13
14	Privacy Fence	2002	2,550	255	10	255		1,296	14
15	Install Temp Control Cartridge-Boiler	2002	537	36	15	36		197	15
16	Internet Set Up Wiring, Cable	2002	3,061	204	10	204		1,105	16
17	Motor Boiler	2002	763	76	10	76		407	17
18	Replace Hallow Metal Door	2002	1,665	111	15	111		564	18
19	Shutters	2002	820	82	10	82		417	19
20	Storm Window Project	2002	8,937	447	20	447		2,272	20
21	Replace Breaker, Ballasts	2002	555	55	5	55		555	21
22	Tennant Allowance to Offset Fix-up Costs	2002	(5,000)	(500)	5	(500)		(5,000)	22
23	New Motor on Boiler	2002	962	96	10	96		481	23
24	Installed Hospital Grade Outlet	2002	2,256	226	10	226		1,109	24
25	Wiring for New Time Clock	2003	634	63	10	63		269	25
26	Motor & Coupler / Circular	2003	835	83	10	83		355	26
27	Side Screens on DT Awning	2003	738	148	5	148		639	27
28	Anne's Landscaping	2004	590	59	10	59		187	28
29	Parking Lot Renovation	2004	3,049	305	10	305		864	29
30	Parking Lot Renovation	2004	450	45	10	45		90	30
31	Fire & Electric System (Part of 298)	2004	435	62	7	62		181	31
32	New Electrical System (Multi Purpose)	2004	6,637	948	7	948		2,687	32
33	Conduit and Wire Hookup	2004	965	97	10	97		249	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,078,711	\$ 81,261		\$ 81,261	\$	\$ 1,847,716	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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:

07/01/06

Ending:

06/30/07

**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	<b>Totals from Page 12C, Carried Forward</b>		\$ 3,078,711	\$ 81,261		\$ 81,261	\$	\$ 1,847,716	1
2	34 Heat / Smoke Detectors	2004	2,800	400	7	400		1,033	2
3	Commerical Disposal	2005	551	79	7	79		197	3
4	18 Kickplates	2005	2,215	222	10	222		535	4
5	Hollow Metal Door	2005	945	63	15	63		131	5
6	Day Training Addition	2005	346,465	11,549	30	11,549		32,722	6
7	3 Window A/C Units	2005	1,755	251	5	251		501	7
8	Compressor in Lobby - Replacement	2005	11,445	763	15	763		1,462	8
9	2 A/C Units	2005	1,170	167	7	167		306	9
10	Booster Pump / Shower Head - Replacement	2005	943	94	10	94		149	10
11	Hot Water Mixing Valve - Replacement	2005	1,168	117	10	117		195	11
12	Install Pull Station / Light / Speaker	2005	1,434	143	10	143		251	12
13	New Roof (down payment)	2006	15,987	1,599	10	1,599		2,132	13
14	Sprinkler System- Phase I	2006	33,165	2,211	15	2,211		2,211	14
15	Water Heater	2006	4,717	472	10	472		472	15
16	3 A/C Units	2006	1,755	251	7	251		251	16
17	Fire Door for Tub Room	2006	640	64	10	64		64	17
18	Sprinkler System- Phase II	2006	7,920	528	15	528		528	18
19	Sprinkler System- Phase III	2006	13,365	668	15	668		668	19
20	Sprinkler System- Phase IV	2006	1,978	77	15	77		77	20
21	Light Fixtures and Wiring	2007	6,434	179	15	179		179	21
22	Ductwork & Roof Exhaust	2007	3,498	78	15	78		78	22
23	Rounding		(3)	(3)		(3)		3	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,539,058	\$ 101,233		\$ 101,233	\$	\$ 1,891,861	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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: 07/01/06 Ending: 06/30/07

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	\$ 121,080	\$ 19,501	\$ 19,501	\$		\$ 68,651	71
72	Current Year Purchases	15,982	876	876			876	72
73	Fully Depreciated Assets	453,832	2,979	2,979			453,832	73
74	Corporate Allocation		29	29				74
75	TOTALS	\$ 590,894	\$ 23,385	\$ 23,385	\$		\$ 523,359	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					26,150	77
78	Patient Transportation	2002 Van	2002	19,705	3,613	3,613			19,705	78
79	Patient Transportation	2002 Van	2002	11,803	2,176	2,176			11,266	79
80	TOTALS			\$ 59,729	\$ 5,789	\$ 5,789	\$		\$ 59,192	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)		\$ 4,603,766	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 130,407	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 130,407	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)		\$ 2,474,412	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	Construction-In-Progress	\$ 2,195	92
93			93
94			94
95		\$ 2,195	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 3,698 Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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? <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)	
<b>TOTAL TRAINED</b>	

- (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.
- SEE ACCOUNTANTS' COMPILATION REPORT

**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 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	<b>TOTAL</b>			\$		\$		\$		\$			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.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 1,526	\$	1
2	Cash-Patient Deposits	59,520		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 2,765 )	1,090,026		3
4	Supply Inventory (priced at <u>Cost</u> )	10,646		4
5	Short-Term Investments			5
6	Prepaid Insurance	43,527		6
7	Other Prepaid Expenses	3,900		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from Corporate</u>	10,584,606		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 11,793,751	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	414,085		13
14	Buildings, at Historical Cost	3,539,058		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	650,623		16
17	Accumulated Depreciation (book methods)	(2,474,412)		17
18	Deferred Charges	302,692		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):	492,388		22
23	Other(specify): <u>Goodwill</u>	458,431		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,382,865	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 15,176,616	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 79,669	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	59,520		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	226,622		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,500		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	34,211		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Accrued HRA</u>	800		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 405,322	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,657,054		41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 5,657,054	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 6,062,376	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 9,114,240	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 15,176,616	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,495,474	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,495,474	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	618,766	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 618,766</b>	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 9,114,240</b>	24 *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care & Training Center

# 0035477

Report Period Beginning: 07/01/06

Ending: 06/30/07

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,026,122	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,026,122	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	187	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	31,000	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 31,187	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	3,214	24
25	Interest and Other Investment Income***	30,085	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 33,299	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>DMH Day Training</u>	1,487,646	28
28a	<u>Miscellaneous Income</u>	267	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,487,913	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,578,521	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	888,316	31
32	Health Care	2,078,782	32
33	General Administration	1,364,320	33
<b>B. Capital Expense</b>			
34	Ownership	547,707	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	790,707	35
36	Provider Participation Fee	289,928	36
<b>D. Other Expenses (specify):</b>			
37	<u>Rounding</u>	(5)	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,959,755	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	618,766	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 618,766	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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Exceptional Care & Training Center

# 0035477

Report Period Beginning: 07/01/06

Ending:

06/30/07

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,173	2,189	\$ 65,437	\$ 29.89	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,538	6,129	149,404	24.38	3
4	Licensed Practical Nurses	21,568	23,784	481,978	20.26	4
5	CNAs & Orderlies	92,815	101,359	1,028,815	10.15	5
6	CNA Trainees					6
7	Licensed Therapist	46	46	3,203	69.63	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,978	2,213	39,940	18.05	9
10	Activity Assistants	18,068	19,499	156,687	8.04	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,493	1,805	35,294	19.55	13
14	Head Cook	8,211	9,079	97,022	10.69	14
15	Cook Helpers/Assistants	7,041	7,435	56,775	7.64	15
16	Dishwashers					16
17	Maintenance Workers	3,611	3,836	56,300	14.68	17
18	Housekeepers	10,492	11,458	100,788	8.80	18
19	Laundry	11,902	13,114	136,447	10.40	19
20	Administrator	1,956	2,005	78,300	39.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,193	4,655	60,321	12.96	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)	55,305	61,661	724,923	11.76	33
34	TOTAL (lines 1 - 33)	246,390	270,267	\$ 3,271,634 *	\$ 12.11	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	127	\$ 5,650	1.3	35
36	Medical Director	176	23,100	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	N/A	1,800	10.3	39
40	Physical Therapy Consultant	150	3,876	10a.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	131	9,158	10a.3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Dental Fees</u>	N/A	3,000	10.3	46
47	<u>Other Plant Operation</u>	N/A	24,866	6.3	47
48	<u>See Attached</u>		2,857		48
49	TOTAL (lines 35 - 48)	584	\$ 74,307		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

SEE ACCOUNTANTS' COMPILATION REPORT



**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
1	None		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

**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. \$ 25,699 Line 10.2
- (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. \$ 289,928  
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. \$ 48,747
- (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 \$5,000, 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.

SEE ACCOUNTANTS' COMPILATION REPORT