

Facility Name & ID Number Exceptional Care & Training Center

0035477 Report Period Beginning: 7/1/07 Ending: 6/30/08

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	<u>84</u>	Skilled Pediatric (SNF/PED)	<u>84</u>	<u>30,744</u>	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>84</u>	TOTALS	<u>84</u>	<u>30,744</u>	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		Total
8	SNF				8	
9	SNF/PED	<u>29,646</u>	<u>57</u>	<u>0</u>	<u>29,703</u>	9
10	ICF				10	
11	ICF/DD				11	
12	SC				12	
13	DD 16 OR LESS				13	
14	TOTALS	<u>29,646</u>	<u>57</u>		<u>29,703</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.61%

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

298 (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: 6/30/08 Fiscal Year: 6/30/08

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

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 7/1/07 Ending: 6/30/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	194,952	15,786	7,657	218,395	8,633	227,028		227,028			1
2	Food Purchase		164,600		164,600		164,600		164,600			2
3	Housekeeping	71,557	11,492		83,049		83,049		83,049			3
4	Laundry	163,705	7,130	14	170,849		170,849		170,849			4
5	Heat and Other Utilities			136,883	136,883	485	137,368		137,368			5
6	Maintenance	65,381	11,584	56,625	133,590	1,647	135,237		135,237			6
7	Other (specify):*											7
8	TOTAL General Services	495,595	210,592	201,179	907,366	10,765	918,131		918,131			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	1,704,445	99,314	3,139	1,806,898	10,515	1,817,413		1,817,413			10
10a	Therapy	39,268	27	5,919	45,214		45,214		45,214			10a
11	Activities	243,163	3,051		246,214		246,214		246,214			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation		9,870		9,870		9,870		9,870			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,986,876	112,262	30,058	2,129,196	10,515	2,139,711		2,139,711			16
	C. General Administration											
17	Administrative	82,286		204,893	287,179	(174,448)	112,731	(30,445)	82,286			17
18	Directors Fees					10,056	10,056		10,056			18
19	Professional Services			414,427	414,427	51,905	466,332		466,332			19
20	Dues, Fees, Subscriptions & Promotions			13,174	13,174	68	13,242	(1,885)	11,357			20
21	Clerical & General Office Expenses	57,525	15,060	30,671	103,256	52,981	156,237	(23)	156,214			21
22	Employee Benefits & Payroll Taxes			589,908	589,908	8,193	598,101		598,101			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,445	12,445	450	12,895	(145)	12,750			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			36,775	36,775		36,775		36,775			26
27	Other (specify):* Bad Debt			(2,753)	(2,753)		(2,753)	2,753				27
28	TOTAL General Administration	139,811	15,060	1,299,540	1,454,411	(50,795)	1,403,616	(29,745)	1,373,871			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,622,282	337,914	1,530,777	4,490,973	(29,515)	4,461,458	(29,745)	4,431,713			29

*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: 7/1/07 Ending: 6/30/08

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
	D. Ownership										
30	Depreciation			124,993	124,993	92	125,085		125,085		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			408,408	408,408	27,824	436,232	(103,797)	332,435		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds					1,643	1,643		1,643		34
35	Rent-Equipment & Vehicles			3,629	3,629	(44)	3,585		3,585		35
36	Other (specify):* Amortization			31,970	31,970		31,970	(22,833)	9,137		36
37	TOTAL Ownership			569,000	569,000	29,515	598,515	(126,630)	471,885		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			288,708	288,708		288,708		288,708		42
43	Other (specify):* Day Training	724,290	4,086	60,254	788,630		788,630		788,630		43
44	TOTAL Special Cost Centers	724,290	4,086	348,962	1,077,338		1,077,338		1,077,338		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,346,572	342,000	2,448,739	6,137,311		6,137,311	(156,375)	5,980,936		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: 7/1/07

Ending: 6/30/08

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	(28,529)	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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	2,753	27		24
25	Fund Raising, Advertising and Promotional	(1,785)	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	(98,269)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (125,930)		\$	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)	(30,445)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (30,445)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (156,375)		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			X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Exceptional Care & Training Center

ID# 0035477

Report Period Beginning: 7/1/07

Ending: 6/30/08

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	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Exceptional Care & Training Center

0035477

Report Period Beginning:

7/1/07

Ending:

6/30/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(30,445)	0	0	0	0	0	0	0	0	0	(30,445)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,885)	0	0	0	0	0	0	0	0	0	0	(1,885)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	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):*	2,753	0	0	0	0	0	0	0	0	0	0	2,753	27
28	TOTAL General Administration	868	(30,445)	0	0	0	0	0	0	0	0	0	(29,577)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	868	(30,445)	0	0	0	0	0	0	0	0	0	(29,577)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Exceptional Care & Training Center

0035477

Report Period Beginning:

7/1/07

Ending:

6/30/08

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	(28,529)	0	0	0	0	0	0	0	0	0	0	(28,529)	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	TOTAL Ownership	(28,529)	0	0	0	0	0	0	0	0	0	0	(28,529)	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)	(27,661)	(30,445)	0	(58,106)	45								

Facility Name & ID Number Exceptional Care & Training Center

0035477

Report Period Beginning:

7/1/07

Ending:

6/30/08

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			
		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	\$ 204,893	Hoosier Care, Inc.	100.00%	\$ 174,448	\$ (30,445)	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		\$ 204,893			\$ 174,448	\$ * (30,445)	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: 7/1/07 Ending: 6/30/08

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	11,466			Director Fees	\$ 2,201	18.8	1
2	Stephen Wood	Director	Board Meetings	0.00	19,820			Director Fees	3,807	18.8	2
3	John Gillmor	Director	Board Meetings	0.00	10,537			Director Fees	2,024	18.8	3
4	John Foos	Director	Board Meetings	0.00	10,537			Director Fees	2,024	18.8	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 10,056		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: 7/1/07

Ending: 6/30/08

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 Street, 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	41,556,567	7	\$ 53,586	\$ 0	6,695,043	\$ 8,633	1
2	5	Heat & Other Utilities	Revenue	41,556,567	7	3,012	0	6,695,043	485	2
3	6	Maintenance	Revenue	41,556,567	7	5,850	0	6,695,043	942	3
4	10	Nursing / Medical Records	Revenue	41,556,567	7	65,268	0	6,695,043	10,515	4
5	18	Director's Fees	Revenue	41,556,567	7	62,416	0	6,695,043	10,056	5
6	19	Professional Fees	Revenue	41,556,567	7	322,175	0	6,695,043	51,905	6
7	20	Fees, Subscription & Promotion	Revenue	41,556,567	7	423	0	6,695,043	68	7
8	21	Clerical & General Office Exp.	Revenue	41,556,567	7	332,808	0	6,695,043	53,618	8
9	22	Emp. Benefits & Payroll Tax	Revenue	41,556,567	7	50,853	0	6,695,043	8,193	9
10	24	Travel & Seminar	Revenue	41,556,567	7	2,795	0	6,695,043	450	10
11	30	Depreciation	Revenue	41,556,567	7	571	0	6,695,043	92	11
12	32	Interest Expense	Revenue	41,556,567	7	172,705	0	6,695,043	27,824	12
13	34	Rent - Facility	Revenue	41,556,567	7	10,200	0	6,695,043	1,643	13
14	35	Rent - Equipment	Revenue	41,556,567	7	150	0	6,695,043	24	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,082,812	\$		\$ 174,448	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			
A. Directly Facility Related																				
Long-Term																				
1	City of Sterling Bonds - 1999A		X	Purchase of Facility	Varies	7/8/99	\$ 4,775,000	\$ 4,375,000	6/1/2034	7.1250	\$ 314,590	1								
2	City of Sterling Bonds - 1999B		X	Purchase of Facility	Varies	7/8/99	220,000	170,000	6/2/2019	10.5000	18,550	2								
3												3								
4												4								
5												5								
Working Capital																				
6	Corporate Allocation										27,824	6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 4,995,000	\$ 4,545,000			\$ 360,964	9								
B. Non-Facility Related*																				
10	Debt Allocation		X	Purchase of Facility	Varies	7/8/99		1,027,776	Varies	Varies	75,268	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$ 1,027,776			\$ 75,268	14								
15	TOTALS (line 9+line14)						\$ 4,995,000	\$ 5,572,776			\$ 436,232	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.)

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

0035477 Report Period Beginning: **7/1/07**

Ending: **6/30/08**

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2007 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2008 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:				
2003	None	8		
2004		9		
2005		10		
2006		11		
2007		12		
Note: The facility became exempt from property taxes starting 1/1/96				
			FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2007	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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	TOTALS	63,598		\$ 414,085	3

SEE ACCOUNTANTS' COMPILATION REPORT

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		\$ 1,401,166	4
5	15			1991	358,311	11,944	30	11,944		203,601	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		75	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:

7/1/07

Ending:

6/30/08**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		10			640	58
59	Install 3/4 H.P. Motor-Boiler	1997	725		10			725	59
60	Replace Circulating Pump, Bearings	1997	743		10			743	60
61	Twenty New Water Faucets	1997	2,296		10			2,296	61
62	Vinyl Floor Tile-Resident Room	1997	690		10			690	62
63	Reseal Parking Area	1997	2,845		10			2,845	63
64	Air Conditioning Condenser Unit	1997	1,650	28	10	28		1,650	64
65	Install Conduit	1997	913	23	10	23		913	65
66	Outlets & Wiring	1997	522	17	10	17		522	66
67	Kitchen Fire Suppression System	1998	767	45	10	45		767	67
68	Smoke Detectors	1998	621	36	10	36		621	68
69	Install Pipe & Wire	1998	995	66	10	66		995	69
70	TOTAL (lines 4 thru 69)		\$ 2,876,859	\$ 70,164		\$ 70,164	\$	\$ 1,789,251	70

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:

7/1/07

Ending:

6/30/08

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	\$ 70,164		\$ 70,164	\$	\$ 1,789,251	1
2	Smoke Detectors	1998	1,644	109	10	109		1,645	2
3	Tank Replacement - PIPECO	1998	9,890	495	20	495		4,863	3
4	Generator and Transfer Switch Changeover	1998	2,746	275	10	275		2,701	4
5	Replace Tubes on Boiler, Galv. Pipes on Water Line	1998	1,690	169	10	169		1,633	5
6	Installed Boiler Control and Switch for Light	1998	709	71	10	71		692	6
7	Replace Faulty Smoke Detectors, Installed Batteries	1998	973	97	10	97		949	7
8	Installed Tile on Walls & in Staircase (New Addition)	1998	4,495	450	10	450		4,308	8
9	Two Hot Water Tanks Installed	1999	7,119	712	10	712		6,645	9
10	Installation Heavier Electric Service for Dishwasher	1999	1,651	165	10	165		1,541	10
11	Install New Cooling System Laundry / Kitchen	2000	4,650	233	20	233		1,976	11
12	Plaster & Drywall Existing Walls in Residents Rooms	2000	800	80	10	80		673	12
13	Install New Tile in Dinning Area & Two Classrooms	2000	4,770	318	15	318		2,624	13
14	Installed New Thermocuople on West Boiler	2000	353	35	10	35		291	14
15	Replace Thermocouple on West Boiler	2000	140	14	10	14		115	15
16	Replace Thermocouple on Inducer Fan	2000	215	21	10	21		177	16
17	Rebuilt Two Hopper Foot Valves / Installed Protectorelay	2000	1,430	143	10	143		1,179	17
18	Replace Coupler, Motor Mounts, Bearing assy, Impeller	2000	298	30	10	30		246	18
19	Labor to Install 120V Power to New Door Openers	2000	583	58	10	58		476	19
20	Replaced Bearing Assy on Hot Water Return Line	2000	518	52	10	52		423	20
21	Indicator Lamps & Voltage	2000	1,525	153	10	153		1,182	21
22	Replace Heat Exchanger	2001	962	96	10	96		721	22
23	Replace Heat Exchanger	2001	962	96	10	96		713	23
24	Replace Draft Inducer	2001	1,414	141	10	141		1,037	24
25	Replace Pipe	2001	530	53	10	53		389	25
26	Replace Clinical Sink	2001	2,304	154	15	154		1,114	26
27	Furnish & Install Awning	2001	2,771	185	15	185		1,340	27
28	Labor & Mat-Breaker Panel	2001	3,930	262	15	262		1,899	28
29	Install Thermo Coupler	2001	944	94	10	94		677	29
30	Install Electric For Dishwasher	2001	820	55	15	55		392	30
31	Reroof Facility and Garage	2001	13,960	558	25	558		4,002	31
32	Lusterboard Sign	2001	515		5			515	32
33	Excavation of New Parking	2001	12,415	621	20	621		4,449	33
34	TOTAL (lines 1 thru 33)		\$ 2,964,585	\$ 76,159		\$ 76,159	\$	\$ 1,840,838	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:

7/1/07

Ending:

6/30/08**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	\$ 76,159		\$ 76,159	\$	\$ 1,840,838	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		5			3,393	4
5	Refund Electrical Panel	2001	(975)		5			(975)	5
6	Install Water Heater	2001	3,341	223	15	223		1,559	6
7	Conduit & Wiring for Door Holders	2001	1,982	132	15	132		925	7
8	Air Conditioning in Lobby-Motor Replacement	2001	349	35	10	35		241	8
9	East Tub Room Fan-Motor Replacement	2001	213	21	10	21		148	9
10	Dryer Vent Replacement	2001	319	32	10	32		221	10
11	Reconfigure Water Heater Room	2001	1,860	124	15	124		847	11
12	Walkway	2001	4,120	275	15	275		1,899	12
13	Hand Railing on Stairs to Upper Parking Lot	2002	2,130	142	15	142		887	13
14	Privacy Fence	2002	2,550	255	10	255		1,551	14
15	Install Temp Control Cartridge-Boiler	2002	537	36	15	36		233	15
16	Internet Set Up Wiring, Cable	2002	3,061	204	10	204		1,309	16
17	Motor Boiler	2002	763	76	10	76		483	17
18	Replace Hallow Metal Door	2002	1,665	111	15	111		675	18
19	Shutters	2002	820	82	10	82		499	19
20	Storm Window Project	2002	8,937	447	20	447		2,718	20
21	Replace Breaker, Ballasts	2002	555		5			555	21
22	Tennant Allowance to Offset Fix-up Costs	2002	(5,000)		5			(5,000)	22
23	New Motor on Boiler	2002	962	96	10	96		577	23
24	Installed Hospital Grade Outlet	2002	2,256	226	10	226		1,335	24
25	Wiring for New Time Clock	2003	634	63	10	63		333	25
26	Motor & Coupler / Circular	2003	835	83	10	83		438	26
27	Side Screens on DT Awning	2003	738	98	5	98		738	27
28	Anne's Landscaping	2004	590	59	10	59		246	28
29	Parking Lot Renovation	2004	3,049	305	10	305		1,169	29
30	Parking Lot Renovation	2004	450	45	10	45		135	30
31	Fire & Electric System (Part of 298)	2004	435	62	7	62		243	31
32	New Electrical System (Multi Purpose)	2004	6,637	948	7	948		3,635	32
33	Conduit and Wire Hookup	2004	965	97	10	97		346	33
34	TOTAL (lines 1 thru 33)		\$ 3,078,711	\$ 80,436		\$ 80,436	\$	\$ 1,928,156	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:

7/1/07

Ending:

6/30/08

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	\$ 80,436		\$ 80,436	\$	\$ 1,928,156	1
2	34 Heat / Smoke Detectors	2004	2,800	400	7	400		1,433	2
3	Commerical Disposal	2005	551	79	7	79		275	3
4	18 Kickplates	2005	2,215	222	10	222		757	4
5	Hollow Metal Door	2005	945	63	15	63		194	5
6	Day Training Addition	2005	346,465	11,549	30	11,549		44,271	6
7	3 Window A/C Units	2005	1,755	251	5	251		752	7
8	Compressor in Lobby - Replacement	2005	11,445	763	15	763		2,225	8
9	2 A/C Units	2005	1,170	167	7	167		474	9
10	Booster Pump / Shower Head - Replacement	2005	943	94	10	94		244	10
11	Hot Water Mixing Valve - Replacement	2005	1,168	117	10	117		311	11
12	Install Pull Station / Light / Speaker	2005	1,434	143	10	143		394	12
13	New Roof (down payment)	2006	15,987	1,599	10	1,599		3,730	13
14	Sprinkler System- Phase I	2006	33,165	2,211	15	2,211		4,422	14
15	Water Heater	2006	4,717	472	10	472		943	15
16	3 A/C Units	2006	1,755	251	7	251		501	16
17	Fire Door for Tub Room	2006	640	64	10	64		128	17
18	Sprinkler System- Phase II	2006	7,920	528	15	528		1,056	18
19	Sprinkler System- Phase III	2006	13,365	891	15	891		1,559	19
20	Sprinkler System- Phase IV	2006	1,978	132	15	132		209	20
21	Light Fixtures and Wiring	2007	6,434	429	15	429		608	21
22	Ductwork & Roof Exhaust	2007	3,498	233	15	233		311	22
23	Brake Assembly on Dumbwaiter	2007	4,389	268	15	268		268	23
24	Air Conditioning Window Units	2007	1,170	167	7	167		167	24
25	Raise Sidewalks	2007	950	95	15	95		95	25
26	Tile Walls	2008	9,300	258	15	258		258	26
27	Privacy Walls	2008	3,297	18	15	18		18	27
28	Pistons & Gears for Water Softner System	2008	947	24	10	24		24	28
29	Door Assembly for Boiler	2007	1,072	107	10	107		107	29
30	Rounding		(2)	(2)		(2)			30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,560,184	\$ 102,029		\$ 102,029	\$	\$ 1,993,890	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: 7/1/07 Ending: 6/30/08

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	\$ 114,917	\$ 18,379	\$ 18,379	\$		\$ 68,000	71
72	Current Year Purchases	18,497	1,464	1,464			1,464	72
73	Fully Depreciated Assets	475,977	2,239	2,239			475,977	73
74	Corporate Allocation		92	92				74
75	TOTALS	\$ 609,391	\$ 22,174	\$ 22,174	\$		\$ 545,441	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	2002 Van	2002	19,705					19,705	77
78	Patient Transportation	2002 Van	2002	11,803	150	150			11,416	78
79	Patient Transportation	See Attached	2008	57,098	732	732			732	79
80	TOTALS			\$ 90,677	\$ 882	\$ 882	\$		\$ 33,924	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)		\$ 4,674,337	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 125,085	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 125,085	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)		\$ 2,573,255	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.

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	<u>Corporate Allocation</u>				<u>1,643</u>			5
6								6
7	TOTAL				\$ 1,643			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 3,585 Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

XIII. EXPENSES RELATING TO 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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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	Other (specify):									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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care & Training Center# 0035477Report Period Beginning: 7/1/07

Ending:

6/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,084	\$	1
2	Cash-Patient Deposits	61,360		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 12)	1,461,939		3
4	Supply Inventory (priced at <u>Cost</u>)	6,653		4
5	Short-Term Investments			5
6	Prepaid Insurance	43,265		6
7	Other Prepaid Expenses	3,900		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from Corporate</u>	10,867,758		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 12,447,959	\$	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	3,560,184		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	700,068		16
17	Accumulated Depreciation (book methods)	(2,573,255)		17
18	Deferred Charges	291,481		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):	488,985		22
23	Other(specify): <u>Goodwill</u>	437,672		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,319,220	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 15,767,179	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 84,686	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	61,360		29
30	Accrued Salaries Payable	240,595		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	33,676		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued HRA</u>	5,830		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 430,647	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,572,776		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)	\$ 5,572,776	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,003,423	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 9,763,756	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 15,767,179	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,114,240	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,114,240	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	649,516	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)	\$ 649,516	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)	\$ 9,763,756	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Exceptional Care & Training Center# 0035477Report Period Beginning: 7/1/07Ending: 6/30/08**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	\$ 5,148,602	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,148,602	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	29,383	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 29,383	23
D. Non-Operating Revenue			
24	Contributions	56,588	24
25	Interest and Other Investment Income***	28,529	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 85,117	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>DMH Day Training</u>	1,522,247	28
28a	<u>Miscellaneous Income</u>	1,487	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,523,734	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,786,836	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	907,366	31
32	Health Care	2,129,196	32
33	General Administration	1,454,411	33
B. Capital Expense			
34	Ownership	569,000	34
C. Ancillary Expense			
35	Special Cost Centers	288,708	35
36	Provider Participation Fee	788,630	36
D. Other Expenses (specify):			
37	<u>Rounding</u>	9	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,137,320	40
41	Income before Income Taxes (line 30 minus line 40)**	649,516	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 649,516	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: 7/1/07

Ending: 6/30/08

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	1,946	2,097	\$ 62,898	\$ 29.99	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,559	8,358	205,954	24.64	3
4	Licensed Practical Nurses	19,325	21,296	435,458	20.45	4
5	CNAs & Orderlies	87,854	96,131	1,000,135	10.40	5
6	CNA Trainees					6
7	Licensed Therapist	2,761	2,821	39,268	13.92	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,973	2,220	41,040	18.49	9
10	Activity Assistants	21,486	23,372	202,123	8.65	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,029	2,168	36,036	16.62	13
14	Head Cook	8,005	8,836	101,653	11.50	14
15	Cook Helpers/Assistants	6,399	6,864	57,263	8.34	15
16	Dishwashers					16
17	Maintenance Workers	4,100	4,454	65,381	14.68	17
18	Housekeepers	6,238	7,007	71,557	10.21	18
19	Laundry	13,720	15,282	163,705	10.71	19
20	Administrator	1,939	2,097	82,286	39.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,661	4,139	57,525	13.90	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)	53,724	60,048	724,290	12.06	33
34	TOTAL (lines 1 - 33)	242,719	267,190	\$ 3,346,572 *	\$ 12.53	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	177	\$ 7,616	1.3	35
36	Medical Director	198	21,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	N/A	1,650	10.3	39
40	Physical Therapy Consultant	40	1,436	10A.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	60	4,398	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Other Plant Operation	N/A	28,935	6.3	47
48	See Attached	N/A	2,645		48
49	TOTAL (lines 35 - 48)	475	\$ 67,680		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

Facility Name & ID Number Exceptional Care & Training Center

Report Period Beginning: 7/1/07

Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
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

Facility Name & ID Number Exceptional Care & Training Center**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. \$ 24,000 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. \$ 288,708
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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 2,734
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. \$ 50,069
- (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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT