FOR BHF USE

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 0048264

Facility Name: Illini Nursing Home d/b/a Illini Restorative Care

Address: 1455 Hospital Road (Number) Silvis (City) 61282 (Zip Code)

County: Rock Island

Telephone Number: (309) 792-7614 **Fax #** (309) 762-7611

HFS ID Number:

Date of Initial License for Current Owners: 08/12/1991

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Diana Bollaert **Telephone Number:** (563) 421-1996
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2010 to 06/30/2011 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.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Mark G. Rogers
(Title) Vice President, Finance/CFO

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	22	Skilled (SNF)	22	8,030	1
2		Skilled Pediatric (SNF/PED)			2
3	53	Intermediate (ICF)	53	19,345	3
4		Intermediate/DD			4
5	45	Sheltered Care (SC)	45	16,425	5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	0	32	7,046	7,078	8
9	SNF/PED					9
10	ICF	5,872	11,150	0	17,022	10
11	ICF/DD					11
12	SC	0	14,259	0	14,259	12
13	DD 16 OR LESS					13
14	TOTALS	5,872	25,441	7,046	38,359	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.58%

D. How many bed-hold days during this year were paid by the Department?
None (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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/12/1991

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/12/1991 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 22 and days of care provided 7,046

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2011 Fiscal Year: 06/30/2011

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

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative C # 0048264 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary			1,641	1,641		1,641		1,641			1
2	Food Purchase		700,679		700,679		700,679	648,058	1,348,737			2
3	Housekeeping		13,812	184,065	197,877		197,877	178,105	375,982			3
4	Laundry							73,579	73,579			4
5	Heat and Other Utilities											5
6	Maintenance		2,265	274,759	277,024		277,024	18,422	295,446			6
7	Other (specify):*							205,227	205,227			7
8	TOTAL General Services		716,756	460,465	1,177,221		1,177,221	1,123,391	2,300,612			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,194,884	37,052	200,559	2,432,495		2,432,495		2,432,495			10
10a	Therapy	358,249	2,356	396	361,001		361,001	(50,436)	310,565			10a
11	Activities	76,539	3,486	11,181	91,206		91,206	(64)	91,142			11
12	Social Services	66,773	190	1,720	68,683		68,683		68,683			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,696,445	43,084	213,856	2,953,385		2,953,385	(50,500)	2,902,885			16
	C. General Administration											
17	Administrative	239,757	7,364	1,231,608	1,478,729		1,478,729	(625,718)	853,011			17
18	Directors Fees											18
19	Professional Services			275	275		275		275			19
20	Dues, Fees, Subscriptions & Promotions			9,327	9,327		9,327	(156)	9,171			20
21	Clerical & General Office Expenses	12	1,341		1,353		1,353		1,353			21
22	Employee Benefits & Payroll Taxes			721,671	721,671		721,671	(338,812)	382,859			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,974	6,974		6,974		6,974			24
25	Other Admin. Staff Transportation			704	704		704		704			25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*											27
28	TOTAL General Administration	239,769	8,705	1,970,559	2,219,033		2,219,033	(964,686)	1,254,347			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,936,214	768,545	2,644,880	6,349,639		6,349,639	108,205	6,457,844			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care #0048264 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			338,804	338,804		338,804		338,804			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			249,896	249,896		249,896	(1,856)	248,040			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			588,700	588,700		588,700	(1,856)	586,844			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		354,545	44	354,589		354,589		354,589			39
40	Barber and Beauty Shops			22,672	22,672		22,672		22,672			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		354,545	22,716	377,261		377,261		377,261			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,936,214	1,123,090	3,256,296	7,315,600		7,315,600	106,349	7,421,949			45

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

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients	(64)	11		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(915)	3		5
6	Rented Facility Space	(50,436)	10a		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	(1,856)	32		10
11	Discounts, Allowances, Rebates & Refunds	(89)	17		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(156)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (53,516)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 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)	159,865		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 159,865		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 106,349		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Illini Nursing Home d/b/a Illini Restorative Care

ID# 0048264

Report Period Beginning: 07/01/2010

Ending: 06/30/2011

	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 Illini Nursing Home d/b/a Illini Restorative Care **#** 0048264 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

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	648,058	0	0	0	0	0	0	0	0	0	648,058	2
3	Housekeeping	(915)	179,020	0	0	0	0	0	0	0	0	0	178,105	3
4	Laundry	0	73,579	0	0	0	0	0	0	0	0	0	73,579	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	18,422	0	0	0	0	0	0	0	0	0	18,422	6
7	Other (specify):*	0	205,227	0	0	0	0	0	0	0	0	0	205,227	7
8	**TOTAL General Services**	(915)	1,124,306	0	0	0	0	0	0	0	0	0	1,123,391	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	(50,436)	0	0	0	0	0	0	0	0	0	0	(50,436)	10a
11	Activities	(64)	0	0	0	0	0	0	0	0	0	0	(64)	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**	(50,500)	0	0	0	0	0	0	0	0	0	0	(50,500)	16
	C. General Administration													
17	Administrative	(89)	(625,629)	0	0	0	0	0	0	0	0	0	(625,718)	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	(156)	0	0	0	0	0	0	0	0	0	0	(156)	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	(338,812)	0	0	0	0	0	0	0	0	0	(338,812)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(245)	(964,441)	0	0	0	0	0	0	0	0	0	(964,686)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(51,660)	159,865	0	0	0	0	0	0	0	0	0	108,205	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

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

	Capital Expense D. Ownership	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)	
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	(1,856)	0	0	0	0	0	0	0	0	0	0	(1,856)	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**	(1,856)	0	0	0	0	0	0	0	0	0	0	(1,856)	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)**	(53,516)	159,865	0	0	0	0	0	0	0	0	0	106,349	45

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Illini Nursing Home	100%	Illini Restorative Care Center	Silvis	Illini Hospital	Silvis	Hospital
				Crosstown Square	Silvis	Senior Apts
				Genesis Health Sys	Davenport	Home Office

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Dietary	$ 702,320	Illini Hospital (B Pt I Allocated Cost)	100.00%	$ 1,350,378	$ 648,058	1
2	V	3	Housekeeping	197,877	Illini Hospital (B Pt I Allocated Cost)	100.00%	376,897	179,020	2
3	V	4	Laundry		Illini Hospital (B Pt I Allocated Cost)	100.00%	73,579	73,579	3
4	V	6	Plant Op/Maintenance	277,024	Illini Hospital (B Pt I Allocated Cost)	100.00%	295,446	18,422	4
5	V	7	Cafeteria		Illini Hospital (B Pt I Allocated Cost)	100.00%	205,227	205,227	5
6	V	10	Nursing Administration	139,078	Illini Hospital (B Pt I Allocated Cost)	100.00%	139,078		6
7	V	11	Activity	91,206	Illini Hospital (B Pt I Allocated Cost)	100.00%	91,206		7
8	V	12	Social Service	68,683	Illini Hospital (B Pt I Allocated Cost)	100.00%	68,683		8
9	V	17	Administrative & General	1,497,362	Illini Hospital (B Pt I Allocated Cost)	100.00%	871,733	(625,629)	9
10	V	22	Employee Benefits	721,671	Illini Hospital (B Pt I Allocated Cost)	100.00%	382,859	(338,812)	10
11	V	30	CRC Bldgs & Fixt-Depr	338,804	Illini Hospital (B Pt I Allocated Cost)	100.00%	338,804		11
12	V	32	CRC Bldgs & Fixt-Interest	249,896	Illini Hospital (B Pt I Allocated Cost)	100.00%	249,896		12
13	V								13
14	Total			$ 4,283,921			$ 4,443,786	$ * 159,865	14

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

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3			NOT APPLICABLE					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

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative C # 0048264 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NOT APPLICABLE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2010 Ending: 6/30/2011

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 [X] NO [ ]

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

Name of Related Organization: Illini Hospital
Street Address: 801 Hospital Road
City / State / Zip Code: Silvis, IL 61285
Phone Number: (309) 792-4268
Fax Number: (309) 792-4274

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Dietary	Meals	339,674	3	$ 3,884,720	$	118,075	$ 1,350,378	1
2	3	Housekeeping	Square Feet	180,965	3	1,537,952		44,348	376,897	2
3	4	Laundry	Linen Lbs.	725,347	3	253,714		210,355	73,579	3
4	6	Plant Op/Maintenance	Square Feet	49,295	3	328,403		44,348	295,446	4
5	7	Cafeteria	FTEs	50,224	3	1,417,395		7,272	205,227	5
6	10	Nursing Administration	Nursing Hours	10,000	3	139,078		10,000	139,078	6
7	11	Activity	Days	1,000	3	91,206		1,000	91,206	7
8	12	Social Service	IRC Discharges	1,000	3	68,683		1,000	68,683	8
9	17	Administrative & General	Accum. Cost	226,443,999	3	16,705,975		11,816,049	871,733	9
10	22	Employee Benefit	Salaries	27,997,860	3	4,843,477		2,213,128	382,859	10
11	30	CRC Bldgs & Fixt-Depr	Square Feet	10,000	3	338,804		10,000	338,804	11
12	32	CRC Bldgs & Fixt-Interest	Square Feet	10,000	3	249,896		10,000	249,896	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					$ 29,859,303	$		$ 4,443,786	25

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative C# 0048264 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	Quad City Bank & Trust		X	Mortgage	$85,370.00	06/28/06	$ 11,000,000	$	07/05/11	0.0690	$	1
2	GMC-Illini	X		Mortgage	$90,699.35	06/02/10	8,958,390	8,151,482	05/30/20	0.0400		2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$176,069.35		$ 19,958,390	$ 8,151,482			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 19,958,390	$ 8,151,482			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 6,345 **Line #** 17

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

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

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care **#** 0048264 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 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 2011 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:		
2006	N/A	8
2007	N/A	9
2008	N/A	10
2009	N/A	11
2010	N/A	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Illini Nursing Home d/b/a Illini Restorative Care COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0048264

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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	NOT APPLICABLE	NOT APPLICABLE	$	$
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 and 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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (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? [X] (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).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	220,902	1993 & 1999	$ 33,442	1
2					2
3	TOTALS	220,902		$ 33,442	3

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	120		1991		$ 584,661	$ 14,617	40	$ 14,617	$	$ 295,985	4
5			2000		5,435,418	135,885	40	135,885		1,472,092	5
6											6
7											7
8											8
	Improvement Type**										
9	Sign Electrical Fee			1991	1,209	46	20	46		1,209	9
10	Legal & Professional			1991	89,731	2,243	40	2,243		45,426	10
11	Field Tests			1991	1,547	39	40	39		783	11
12	Time & Material Work			1991	17,753	444	40	444		8,987	12
13	Kitchen Plan			1991	1,025	26	40	26		519	13
14	Heating/Ventiliation/Air Conditioning			1991	27,371	684	40	684		13,856	14
15	Pipe Recepticals, Ect			1991	7,746	310	25	310		6,274	15
16	Kitchen & Lounge			1991	40,623	1,016	40	1,016		20,566	16
17	Copper Wire			1991	3,981	149	20	149		3,981	17
18	Sewer Line & Overbed			1991	18,770	704	20	704		18,770	18
19	Elevator Auto Ret Sy			1991	1,042	39	20	39		1,042	19
20	Sheet Metal			1991	3,843	144	20	144		3,843	20
21	Wood Doors & Frames; Hardware			1991	53,541	2,008	20	2,008		53,541	21
22	Metal Windows			1991	13,134	493	20	493		13,134	22
23	Alum Entrances & Storefront			1991	7,608	285	20	285		7,608	23
24	Ceramic Tile			1991	3,575	134	20	134		3,575	24
25	Plumbing, Sprinkler Work			1991	211,741	7,940	20	7,940		211,741	25
26	Electrical			1991	128,975	4,837	20	4,837		128,975	26
27	Plumbing & Electrical			1991	44,800	1,680	20	1,680		44,800	27
28	Building			1991	88,055	2,201	40	2,201		44,578	28
29	Cabinets, Casework			1991	23,231	871	20	871		23,231	29
30	Elevators			1991	13,665	512	20	512		13,665	30
31	Vinyl			1992	578	29	20	29		537	31
32	Air Compressor for Chillr			1997	14,196	946	15	946		12,856	32
33	Remodel IRC Nurse Station-Electrical and Woodwork			1997	3,340	223	15	223		3,154	33
34	Cabinets/Storage-Util Rm			1997	4,103	274	15	274		3,875	34
35	Tie-In Piping Hot Water to IRC			1998	1,766	88	20	88		1,104	35
36											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

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Double Egress Wood Doors	1998	$ 2,756	$ 184	15	$ 184	$	$ 2,419	37
38	Wood Replace Doors-IRC 4 Rooms	1999	1,308	87	15	87		1,003	38
39	4 Inch Sprinkler	2000	18,675	747	25	747		8,590	39
40	Data Voice Wiring-SC	2000	31,453	1,573	10	1,573		31,453	40
41	Door Alarm-Sheltered Care	2000	2,211	111	10	111		2,211	41
42	Analog Message-Sheltered Care	2000	2,693	135	10	135		2,693	42
43	Phone System-Sheltered Care	2000	25,643	1,282	10	1,282		25,643	43
44	IRC Roof Hatches	2001	2,420	121	10	121		2,420	44
45	Door and Door Closers Exam Room	2001	1,524	102	15	102		1,067	45
46	Carpentry Patient Room Showers	2001	9,326	622	15	622		6,528	46
47	Sheltered Care Addition	2001	(196,204)	(4,905)	40	(4,905)		(49,051)	47
48	Air Cond/Handling Unit	2001	2,187	109	10	109		2,187	48
49	Nurse Call System-SC	2001	6,498	325	10	325		6,498	49
50	Kitchen Cabinets-SC	2001	4,077	272	15	272		2,854	50
51	IRC Boiler Stack	2001	14,750	738	20	738		7,744	51
52	PA System IRC Dining Room	2001	1,682	84	10	84		1,682	52
53	Door Wooden IRC	2001	1,465	98	15	98		928	53
54	Concrete Replacement	2001	2,239	149	15	149		1,567	54
55	IRC Wall Hydrants	2002	1,354	135	10	135		1,286	55
56	IRC Wanderguard Relocation	2002	3,122	312	10	312		2,966	56
57	Medicare Rooms Wall Guards	2002	772	77	10	77		733	57
58	Auto Valve Control Upgrade	2002	3,328	333	10	333		3,161	58
59	IRC Cooling Unit Controls	2002	4,567	457	10	457		4,339	59
60	Double Egress Door Replacement	2002	4,342	217	20	217		2,063	60
61	IRC Bedpan Washers	2002	2,923	195	15	195		1,851	61
62	Switchboard Cable IRC	2002	4,831	483	10	483		4,590	62
63	Boiler Fail Over Controls	2002	1,905	191	10	191		1,810	63
64	Parking Lot Lights NW Area	2002	9,535	953	10	953		9,058	64
65	Security System	2003	6,267	627	10	627		5,327	65
66	IRC Loading Dock	2003	97,613	3,905	25	3,905		33,189	66
67	Bronze Circulating Pump	2003	1,937	194	10	194		1,646	67
68	IRC Door Alarm	2003	5,792	579	10	579		4,923	68
69	Canopy	2003	2,275	152	15	152		1,138	69
70	TOTAL (lines 4 thru 69)		$ 6,932,294	$ 189,511		$ 189,511	$	$ 2,596,223	70

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

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,932,294	$ 189,511		$ 189,511	$	$ 2,596,223	1
2	Architect Fees	2004	41,400	1,035	40	1,035		7,763	2
3	Blue Prints PT	2004	36	1	40	1		7	3
4	PT Construction	2004	80,180	2,005	40	2,005		15,034	4
5	PT Construction	2004	93,098	2,327	40	2,327		17,456	5
6	Architect Fees IRC Laundry	2004	7,056	176	40	176		1,323	6
7	Blue Prints IRC Laundry	2004	122	3	40	3		23	7
8	Construction IRC Laundry	2004	24,446	611	40	611		4,584	8
9	Contact Services IRC Laundry	2004	60,362	1,509	40	1,509		11,318	9
10	Rvs Arch Fees Already Cap	2004	(1,655)	(41)	40	(41)		(310)	10
11	Blue Prints IRC Laundry Rvs	2004	(122)	(3)	40	(3)		(23)	11
12	Contract Serv IRC Laun Rvs	2004	(3,023)	(76)	40	(76)		(567)	12
13	Air/Dirt Separator	2004	4,905	491	10	491		3,188	13
14	Air Handling IRC Laundry	2004	19,065	953	20	953		7,149	14
15	Rvs Air Handling Cap FY03	2004	(19,065)	(953)	20	(953)		(7,149)	15
16	Boiler Replacement Deaerator	2005	24,668	1,774	15	1,774		9,588	16
17	Roof	2005	51,860	5,186	10	5,186		28,523	17
18	Acuator Controls	2005	4,092	205	20	205		1,125	18
19	Conduit & Wiring	2005	1,539	77	20	77		423	19
20	Construction	2005	199,131	19,913	10	19,913		109,522	20
21	Design Fees	2005	15,555	1,556	10	1,556		8,555	21
22	Landscaping	2005	2,511	251	10	251		1,381	22
23	Valve Replacements	2006	12,432	622	20	622		3,419	23
24	Design Fees	2006	1,601	160	10	160		880	24
25	Hollow Metal Doors	2006	10,987	549	20	549		3,021	25
26	Electric Switch Gear	2006	3,719	248	15	248		1,116	26
27	Drapes (Fabric & Sheer)	2006	2,304	230	5	230		2,304	27
28	IRC Boiler Tank	2008	3,373	337	10	337		1,181	28
29	IRC Boiler Replacement	2008	99,083	5,828	17	5,828		14,571	29
30	Replace Nurse Call System	2008	60,202	6,020	10	6,020		15,050	30
31	Door Hold - Magnetic	2008	1,404	140	10	140		351	31
32	Fire Damper Doors LSC Survey	2008	7,877	394	20	394		985	32
33	Nurse Call System	2008	54,966	5,497	10	5,497		13,741	33
34	TOTAL (lines 1 thru 33)		$ 7,796,403	$ 246,536		$ 246,536	$	$ 2,871,755	34

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

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 7,796,403	$ 246,536		$ 246,536	$	$ 2,871,755	1
2	Air Conditioning/Cooling	2008	4,050	810	5	810		2,025	2
3	Boiler Replacement	2008	432,708	21,635	20	21,635		54,088	3
4	Repair Sidewalk LSC Survey	2008	2,257	150	15	150		527	4
5	Replace Asphalt Entry Drive	2008	23,800	1,587	15	1,587		3,967	5
6	Replace Corridor Doors	2009	15,509	1,034	15	1,034		2,585	6
7	Magnetic Door Holder	2009	1,334	133	10	133		334	7
8	Replace Fire Alarm Panel	2009	62,446	6,245	10	6,245		15,612	8
9	Replace Chiller Module IRC	2009	14,723	1,472	10	1,472		2,208	9
10	Domestic Hot Water Pumps	2009	56,488	3,766	15	3,766		5,649	10
11	Sprinkler System Internal	2010	50,187	2,007	25	2,007		3,011	11
12	Remodel 8 Private Rooms-Flooring and electical work	2010	44,255	2,950	15	2,950		4,426	12
13	Emerg Power IRC Pt Rooms	2010	15,721	1,048	15	1,048		1,572	13
14	Remodel 8 Private Rooms-Blinds and Cornices	2010	7,888	1,578	5	1,578		2,366	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,527,769	$ 290,951		$ 290,951	$	$ 2,970,125	34

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

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 432,333	$ 44,359	$ 44,359	$		$ 821,180	71
72	Current Year Purchases	54,630	3,496	3,496			3,496	72
73	Fully Depreciated Assets	535,349						73
74								74
75	TOTALS	$ 1,022,312	$ 47,855	$ 47,855	$		$ 824,676	75

D. Vehicle Costs. (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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 9,583,523	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 338,806	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 338,806	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)	$ 3,794,801	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.

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

PLEASE ENTER ONLY DATES IN CELLS W16 AND W17

1. Name of Party Holding Lease: N/A

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:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
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: ____ *

10. Effective dates of current rental agreement:
Beginning N/A
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ Description:
(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	N/A		$	$	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.

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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

	1	2	3	4	5	6	7	8	
	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	39	# of prescrpts				241,786		241,786	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			$		$	$ 241,786		$ 241,786	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.

STATE OF ILLINOIS

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2011 (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	$ 584,813	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 510,764)	798,697		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	12,965		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due From Affiliates	33,398		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,429,873	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	57,723		13
14	Buildings, at Historical Cost	13,524,581		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,834,919		16
17	Accumulated Depreciation (book methods)	(8,350,106)		17
18	Deferred Charges			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):			22
23	Other(specify): CIP	215,280		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,282,397	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,712,270	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 169,445	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	776,465		29
30	Accrued Salaries Payable	240,554		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,950		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Affiliate and Third Party Payables	477,960		36
37	Other Accrued Expenses	105,509		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,772,883	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	7,375,017		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Other-Accrued Pension Costs	2,900		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 7,377,917	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,150,800	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (438,530)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,712,270	$	48

*(See instructions.)

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care **#** 0048264 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (376,416)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (376,416)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)		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)**	$	17
	B. Transfers (Itemize):		
18	**System Undistributed Earnings**	(62,114)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (62,114)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (438,530)	24 *

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

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,748,783	1
2	Discounts and Allowances for all Levels	(2,459,018)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,289,765	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	37,187	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	14,063	15
16	Rental of Facility Space	50,436	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 101,686	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,856	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,856	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Misc Admin	36,409	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 36,409	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,429,716	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,177,221	31
32	Health Care	2,953,385	32
33	General Administration	2,219,033	33
	B. Capital Expense		
34	Ownership	588,700	34
	C. Ancillary Expense		
35	Special Cost Centers	377,261	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Non-Allowable Expenses	1,176,232	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,491,832	40
41	**Income before Income Taxes (line 30 minus line 40)****	(62,116)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (62,116)	43

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

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

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

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

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,850	2,106	$ 87,033	$ 41.33	1
2	Assistant Director of Nursing					2
3	Registered Nurses	36,310	39,339	563,523	14.32	3
4	Licensed Practical Nurses	38,218	41,656	386,121	9.27	4
5	CNAs & Orderlies	116,953	127,872	816,787	6.39	5
6	CNA Trainees					6
7	Licensed Therapist	6,831	7,053	209,216	29.66	7
8	Rehab/Therapy Aides	8,536	9,746	123,856	12.71	8
9	Activity Director	2,081	2,312	34,117	14.76	9
10	Activity Assistants	4,412	5,098	42,587	8.35	10
11	Social Service Workers	1,869	2,168	43,544	20.08	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,618	2,986	123,691	41.42	20
21	Assistant Administrator	7,035	7,897	196,191	24.84	21
22	Other Administrative	12,450	14,507	198,829	13.71	22
23	Office Manager	1,983	2,230	40,344	18.09	23
24	Clerical	4,879	5,349	70,374	13.16	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)					33
34	TOTAL (lines 1 - 33)	246,025	270,319	$ 2,936,213 *	$ 10.86	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DeShawn Schmidt	Exec. Director		$ 68,961
Other Administrative	Business Office		170,796
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 239,757

B. Administrative - Other

Description	Amount
Corporate Allocations	$ 1,110,638
Telephone	33,701
Insurance	14,223
Other Administrative	73,046
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,231,608
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR R Consulting		$ 275
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 275

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ (14,983)
Unemployment Compensation Insurance	
FICA Taxes	213,080
Employee Health Insurance	291,886
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	116,952
Employee Assistance Program	3,958
Long Term Disability	11,440
Life Insurance	5,131
Other Benefits	94,207
Hospital OH Allocation Adj	
TOTAL (agree to Schedule V, line 22, col.8)	$ 721,671

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues Ill. Council Long Term Care	5,354
Dues Ill. Nrsg Home Admin. Assoc.	100
Other Dues/Subscriptions	3,717
Adv and Promotions	156
Less: Public Relations Expense	( )
Non-allowable advertising	(156)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,171

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Education & Travel	6,974
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,974

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	NOT APPLICABLE		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care **#** 0048264 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

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**

(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?

(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?

(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? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,071** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **0**
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? **No** 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. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
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. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
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? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **McGladrey & Pullen**

(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.