FOR BHF USE

LL1

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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0048264

Facility Name: Illini Restorative Care

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

County: Rock Island

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

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 07/01/2011 to 06/30/2012 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 Restorative Care # 0048264 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	22	6,947	6,969	8
9	SNF/PED					9
10	ICF	6,045	9,767	0	15,812	10
11	ICF/DD					11
12	SC	0	11,641	0	11,641	12
13	DD 16 OR LESS					13
14	TOTALS	6,045	21,430	6,947	34,422	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.59%

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 6,947

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: 06/30/2012 Fiscal Year: 06/30/2012

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

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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			494	494		494		494			1
2	Food Purchase		636,713		636,713		636,713	307,010	943,723			2
3	Housekeeping	164,713	14,247	58,062	237,022		237,022	(17,660)	219,362			3
4	Laundry							33,140	33,140			4
5	Heat and Other Utilities											5
6	Maintenance		3,535	228,687	232,222		232,222	(31,575)	200,647			6
7	Other (specify):*							170,013	170,013			7
8	TOTAL General Services	164,713	654,495	287,243	1,106,451		1,106,451	460,928	1,567,379			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,311,763	36,641	206,489	2,554,893		2,554,893	107,587	2,662,480			10
10a	Therapy	428,567	2,017		430,584		430,584	(52,452)	378,132			10a
11	Activities	82,752	3,800	7,958	94,510		94,510		94,510			11
12	Social Services	71,174	1,874	162	73,210		73,210		73,210			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,894,256	44,332	214,609	3,153,197		3,153,197	55,135	3,208,332			16
	C. General Administration											
17	Administrative	249,642	9,064	1,403,933	1,662,639		1,662,639	(473,073)	1,189,566			17
18	Directors Fees											18
19	Professional Services			515	515		515		515			19
20	Dues, Fees, Subscriptions & Promotions			8,233	8,233		8,233		8,233			20
21	Clerical & General Office Expenses	33,718			33,718		33,718		33,718			21
22	Employee Benefits & Payroll Taxes			830,222	830,222		830,222	(149,984)	680,238			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,737	5,737		5,737	(114)	5,623			24
25	Other Admin. Staff Transportation			1,547	1,547		1,547		1,547			25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*											27
28	TOTAL General Administration	283,360	9,064	2,250,187	2,542,611		2,542,611	(623,171)	1,919,440			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,342,329	707,891	2,752,039	6,802,259		6,802,259	(107,108)	6,695,151			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 Restorative Care #0048264 **Report Period Beginning:** 07/01/2011 **Ending:** 06/30/2012

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			329,047	329,047		329,047	(145,416)	183,631			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			227,707	227,707		227,707	(578)	227,129			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			556,754	556,754		556,754	(145,994)	410,760			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		350,710	395	351,105		351,105	11,736	362,841			39
40	Barber and Beauty Shops		88	18,996	19,084		19,084		19,084			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		350,798	19,391	370,189		370,189	11,736	381,925			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,342,329	1,058,689	3,328,184	7,729,202		7,729,202	(241,366)	7,487,836			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 Restorative Care # 0048264 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	(45,387)	10		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(725)	3		5
6	Rented Facility Space	(52,452)	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	(578)	32		10
11	Discounts, Allowances, Rebates & Refunds	(114)	24		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	(55,760)	3		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	(41,176)	10		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(369)	10		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (196,561)		$	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)	(44,805)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (44,805)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (241,366)		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 Restorative Care

ID# 0048264

Report Period Beginning: 07/01/2011

Ending: 06/30/2012

	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
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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 Restorative Care # 0048264 **Report Period Beginning:** 07/01/2011 **Ending:** 06/30/2012

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	307,010	0	0	0	0	0	0	0	0	0	307,010	2
3	Housekeeping	(56,485)	38,825	0	0	0	0	0	0	0	0	0	(17,660)	3
4	Laundry	0	33,140	0	0	0	0	0	0	0	0	0	33,140	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	(31,575)	0	0	0	0	0	0	0	0	0	(31,575)	6
7	Other (specify):*	0	170,013	0	0	0	0	0	0	0	0	0	170,013	7
8	**TOTAL General Services**	(56,485)	517,413	0	0	0	0	0	0	0	0	0	460,928	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	(86,932)	194,519	0	0	0	0	0	0	0	0	0	107,587	10
10a	Therapy	(52,452)	0	0	0	0	0	0	0	0	0	0	(52,452)	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**	(139,384)	194,519	0	0	0	0	0	0	0	0	0	55,135	16
	C. General Administration													
17	Administrative	0	(473,073)	0	0	0	0	0	0	0	0	0	(473,073)	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	0	0	0	0	0	0	0	0	0	0	0	0	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	(149,984)	0	0	0	0	0	0	0	0	0	(149,984)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(114)	0	0	0	0	0	0	0	0	0	0	(114)	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**	(114)	(623,057)	0	0	0	0	0	0	0	0	0	(623,171)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(195,983)	88,875	0	0	0	0	0	0	0	0	0	(107,108)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Illini Restorative Care **#** 0048264 **Report Period Beginning:** 07/01/2011 **Ending:** 06/30/2012

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	(145,416)	0	0	0	0	0	0	0	0	0	(145,416)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(578)	0	0	0	0	0	0	0	0	0	0	(578)	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**	(578)	(145,416)	0	0	0	0	0	0	0	0	0	(145,994)	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	11,736	0	0	0	0	0	0	0	0	0	11,736	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	11,736	0	0	0	0	0	0	0	0	0	11,736	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(196,561)	(44,805)	0	0	0	0	0	0	0	0	0	(241,366)	45

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	$ 636,713	Illini Hospital (B Pt I Allocated Cost)	100.00%	$ 943,723	$ 307,010	1
2	V	3	Housekeeping	237,022	Illini Hospital (B Pt I Allocated Cost)	100.00%	275,847	38,825	2
3	V	4	Laundry		Illini Hospital (B Pt I Allocated Cost)	100.00%	33,140	33,140	3
4	V	6	Plant Op/Maintenance	232,222	Illini Hospital (B Pt I Allocated Cost)	100.00%	200,647	(31,575)	4
5	V	7	Cafeteria		Illini Hospital (B Pt I Allocated Cost)	100.00%	170,013	170,013	5
6	V	10	Nursing Administration		Illini Hospital (B Pt I Allocated Cost)	100.00%	136,883	136,883	6
7	V	17	Administrative & General	1,662,639	Illini Hospital (B Pt I Allocated Cost)	100.00%	1,189,566	(473,073)	7
8	V	22	Employee Benefits	586,116	Illini Hospital (B Pt I Allocated Cost)	100.00%	436,132	(149,984)	8
9	V	30	CRC Bldgs & Fixt-Depr	556,753	Illini Hospital (B Pt I Allocated Cost)	100.00%	411,337	(145,416)	9
10	V	10	Medical Records		Illini Hospital (B Pt I Allocated Cost)	100.00%	57,636	57,636	10
11	V	39	Central Supply	395	Illini Hospital (B Pt I Allocated Cost)	100.00%	12,131	11,736	11
12	V								12
13	V								13
14	Total			$ 3,911,860			$ 3,867,055	$ * (44,805)	14

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

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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 Restorative Care # 0048264 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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 Restorative Care # 0048264 Report Period Beginning: 07/01/2011 Ending: 6/30/2012

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 61282
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	1,000	3	$ 943,723	$	1,000	$ 943,723	1
2	3	Housekeeping	Square Feet	1,000	3	275,847		1,000	275,847	2
3	4	Laundry	Linen Lbs.	1,000	3	33,140		1,000	33,140	3
4	6	Plant Op/Maintenance	Square Feet	50,177	3	227,020		44,348	200,647	4
5	7	Cafeteria	FTEs	49,694	3	1,158,933		7,290	170,013	5
6	10	Nursing Administration	Nursing Hours	405,376	3	1,649,991		33,630	136,883	6
7	17	Administrative & General	Accum. Cost	58,871,709	3	14,020,362		4,995,006	1,189,566	7
8	22	Employee Benefit	Salaries	28,867,450	3	3,994,997		3,151,443	436,132	8
9	30	CRC Bldgs & Fixt-Depr	Square Feet	52,420	3	486,207		44,348	411,337	9
10	10	Medical Records	Revenue	205,191,589	3	1,529,278		7,733,389	57,636	10
11	39	Central Services	Costed Requisitions	8,972,702	3	1,291,307		84,293	12,131	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 25,610,805	$		$ 3,867,055	25

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	7,375,017	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	$ 7,375,017			$	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	$ 7,375,017			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 6,569** **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 Restorative Care # 0048264 **Report Period Beginning:** 07/01/2011 **Ending:** 06/30/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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 2012 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:			
	2007	N/A	8
	2008	N/A	9
	2009	N/A	10
	2010	N/A	11
	2011	N/A	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2011 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 2011.

	(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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 Restorative Care # 0048264 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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 Restorative Care # 0048264 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	$	$ 310,601	4
5			2000		5,435,418	135,885	40	135,885		1,607,978	5
6											6
7											7
8											8
	Improvement Type**										
9	Legal & Professional			1991	89,731	2,243	40	2,243		47,670	9
10	Field Tests			1991	1,547	39	40	39		822	10
11	Time & Material Work			1991	17,753	444	40	444		9,431	11
12	Kitchen Plan			1991	1,025	26	40	26		544	12
13	Heating/Vent/Air Conditioning			1991	27,371	684	40	684		14,541	13
14	Co29-Pipe Recepticals, etc.			1991	7,746	310	25	310		6,584	14
15	Co#23-Kitchen & Lounge			1991	40,623	1,016	40	1,016		21,581	15
16	Building			1991	88,055	2,201	40	2,201		46,779	16
17	Vinyl			1992	578	29	20	29		566	17
18	Elec & Woodworking IRC Nurse Station			1997	3,340	186	15	186		3,340	18
19	Cabinets/Storage-Util Room			1997	4,103	228	15	228		4,103	19
20	Air Compressor for Chillr			1997	14,196	946	15	946		13,802	20
21	Double Egress Wood Doors			1998	2,756	184	15	184		2,602	21
22	Tie-In Piping Hot Water to IRC			1998	1,766	88	20	88		1,192	22
23	Wood Replace Doors-IRC 4 Rooms			1999	1,308	87	15	87		1,090	23
24	4" Sprinkler			2000	18,675	747	25	747		9,337	24
25	Kitchen Cabinets-SC			2001	4,077	272	15	272		3,125	25
26	Door and Door Closers Exam Room			2001	1,524	102	15	102		1,168	26
27	Carpentry Patient Room Showers			2001	9,326	622	15	622		7,150	27
28	IRC Boiler Stack			2001	14,750	738	20	738		6,481	28
29	Concrete Replacement			2001	2,239	149	15	149		1,717	29
30	Sheltered Care Addition			2001	(196,204)	(4,905)	40	(4,905)		(53,956)	30
31	Door Wooden IRC			2001	1,465	98	15	98		1,026	31
32	IRC Wall Hydrants			2002	1,354	68	10	68		1,354	32
33	IRC Wanderguard Relocation			2002	3,122	156	10	156		3,122	33
34	Medicare Rooms Wall Guards			2002	772	39	10	39		772	34
35	Ahu Valve Control Upgrade			2002	3,328	166	10	166		3,328	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 Restorative Care # 0048264 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	IRC Cooling Unit Controls	2002	$ 4,567	$ 228	10	$ 228	$	$ 4,567	37
38	IRC Bedpan Washers	2002	2,923	195	15	195		2,046	38
39	Switchboard Cable IRC	2002	4,831	242	10	242		4,831	39
40	Boiler Fail Over Controls	2002	1,905	95	10	95		1,905	40
41	Parking Lot Lights NW Area	2002	9,535	477	10	477		9,535	41
42	Double Egress Door Replacement	2002	4,342	217	20	217		2,280	42
43	Bronze Circulating Pump	2003	1,937	194	10	194		1,840	43
44	Security System	2003	6,267	627	10	627		5,954	44
45	IRC Loading Dock	2003	97,613	3,905	25	3,905		37,093	45
46	IRC Door Alarm	2003	5,792	579	10	579		5,503	46
47	Canopy	2003	2,275	152	15	152		1,289	47
48	Architect Fees	2004	41,400	1,035	40	1,035		8,798	48
49	Blue Prints PT	2004	36	1	40	1		8	49
50	PT Construction	2004	80,180	2,005	40	2,005		17,038	50
51	PT Construction	2004	93,098	2,327	40	2,327		19,783	51
52	Architect Fees IRC Laundry	2004	7,056	176	40	176		1,499	52
53	Blue Prints IRC Laundry	2004	122	3	40	3		26	53
54	Construction IRC Laundry	2004	24,446	611	40	611		5,195	54
55	Contract Services IRC Laundry	2004	60,362	1,509	40	1,509		12,827	55
56	rvs Arch Fees Already Cap	2004	(1,655)	(41)	40	(41)		(352)	56
57	Blue Prints IRC Laundry Rvs	2004	(122)	(3)	40	(3)		(26)	57
58	Contract Serv IRC Laundry Rvs	2004	(3,023)	(76)	40	(76)		(642)	58
59	Air Handling IRC Laundry	2004	19,065	953	20	953		8,103	59
60	Rvs Air Handling Cap FY03	2004	(19,065)	(953)	20	(953)		(8,103)	60
61	Air/Dirt Separator	2004	4,905	491	10	491		3,679	61
62	Boiler Replacement Deaerator	2005	24,668	1,774	15	1,774		11,362	62
63	Roof	2005	51,860	5,186	10	5,186		33,709	63
64	Acuator Controls	2005	4,092	205	20	205		1,330	64
65	Landscaping	2005	2,511	251	10	251		1,632	65
66	Conduit & Wiring	2005	1,539	77	20	77		500	66
67	Construction	2005	199,131	19,913	10	19,913		129,435	67
68	Design Fees	2005	15,555	1,556	10	1,556		10,111	68
69	Valve Replacements	2006	12,432	622	20	622		4,040	69
70	TOTAL (lines 4 thru 69)		$ 6,946,985	$ 201,994		$ 201,994	$	$ 2,414,646	70

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

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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		$ 6,946,985	$ 201,994		$ 201,994	$	$ 2,414,646	1
2	Design Fees	2006	1,601	160	10	160		1,041	2
3	Hollow Metal Doors	2006	10,987	549	20	549		3,571	3
4	Electric Switch Gear	2006	3,719	248	15	248		1,364	4
5	IRC Boiler Tank	2008	3,373	337	10	337		1,518	5
6	Repair Sidewalk LSC Survey	2008	2,257	150	15	150		677	6
7	Door Hold - Magnetic	2008	1,404	140	10	140		491	7
8	Nurse Call System	2008	54,966	5,497	10	5,497		19,238	8
9	Air Conditioning/Cooling	2008	4,050	810	5	810		2,835	9
10	Boiler Replacement	2008	432,708	21,635	20	21,635		75,724	10
11	IRC Boiler Replacement	2008	99,083	5,828	17	5,828		20,399	11
12	Replace Nurse Call System	2008	60,202	6,020	10	6,020		21,071	12
13	Fire Damper Doors LSC Survey	2008	7,877	394	20	394		1,379	13
14	Replace Asphalt Entry Drive	2008	23,800	1,587	15	1,587		5,553	14
15	Replace Corridor Doors	2009	15,509	1,034	15	1,034		3,619	15
16	Magnetic Door Holder	2009	1,334	133	10	133		467	16
17	Replace Fire Alarm Panel	2009	62,446	6,245	10	6,245		21,856	17
18	Domestic Hot Water Pumps	2009	56,488	3,766	15	3,766		9,415	18
19	Replace Chiller Module IRC N	2009	14,723	1,472	10	1,472		3,681	19
20	Sprinkler System Internal	2010	50,187	2,007	25	2,007		5,019	20
21	Remodel 8 Private Rooms-flooring & electrical work	2010	44,255	2,950	15	2,950		7,376	21
22	Remodel 8 Private Rooms-Blinds and Cornices	2010	7,888	1,578	5	1,578		3,944	22
23	Emerg Power IRC Pt Rooms	2010	15,721	1,048	15	1,048		2,620	23
24	Replace Old Roof Section - IRC	2011	122,994	6,150	10	6,150		6,150	24
25	Storm Sewer Repair	2011	4,434	89	25	89		89	25
26	Air Conditioner Replace IRC	2011	5,265	176	15	176		176	26
27	Upgrade Entrances to Handicap	2011	10,023	501	10	501		501	27
28	Handicap Door Access	2011	2,867	143	10	143		143	28
29	Lighting for IRC	2012	10,519	526	10	526		526	29
30	Add AC Units to Cool Offices	2012	13,450	673	10	673		673	30
31	Feed Wiring for New Sign	2012	1,250	31	20	31		31	31
32	New Freestanding Sign	2012	5,905	295	10	295		295	32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,098,268	$ 274,167		$ 274,167	$	$ 2,636,085	34

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

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	$ 486,963	$ 46,540	$ 46,540	$		$ 335,867	71
72	Current Year Purchases	24,489	1,656	1,656			1,656	72
73	Fully Depreciated Assets	531,125					531,125	73
74								74
75	TOTALS	$ 1,042,577	$ 48,196	$ 48,196	$		$ 868,648	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)	$ 9,174,287	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 322,363	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 322,363	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)	$ 3,504,733	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 Restorative Care # 0048264 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	$
13.	/2014	$
14.	/2015	$

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 Restorative Care # 0048264 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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 Restorative Care # 0048264 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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				260,353		260,353	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			$		$	$ 260,353		$ 260,353	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 Restorative Care # 0048264 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2012 (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	$ 542,305	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 537,364)	1,503,987		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	11,964		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Affiliates	64,965		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,123,221	$	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	13,975,609		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,829,542		16
17	Accumulated Depreciation (book methods)	(8,748,681)		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	290,467		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,404,660	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,527,881	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 222,987	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	808,100		29
30	Accrued Salaries Payable	281,252		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,528		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 & Third Party Payable	635,517		36
37	Other Accrued Expenses	102,565		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,054,949	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,566,922		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Other Accrued Pension Cost	27,100		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 6,594,022	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,648,971	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 878,910	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,527,881	$	48

***(See instructions.)**

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,246,899	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,246,899	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(367,989)	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)**	$ (367,989)	17
	B. Transfers (Itemize):		
18	System Undistributed Earnings		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)**	$ 878,910	24 *

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

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,724,435	1
2	Discounts and Allowances for all Levels	(2,454,891)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,269,544	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	35,703	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	13,730	15
16	Rental of Facility Space	52,452	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)**	$ 101,885	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	578	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 578	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Misc Admin	34,097	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 34,097	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,406,104	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,106,451	31
32	Health Care	3,153,197	32
33	General Administration	2,542,611	33
	B. Capital Expense		
34	Ownership	556,754	34
	C. Ancillary Expense		
35	Special Cost Centers	370,189	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Nonallowable Expenses	1,044,891	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,774,093	40
41	**Income before Income Taxes (line 30 minus line 40)****	(367,989)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (367,989)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	49

* **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 Restorative Care # 0048264 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	1,961	2,296	$ 92,187	$ 40.15	1
2	Assistant Director of Nursing					2
3	Registered Nurses	41,725	44,889	590,634	13.16	3
4	Licensed Practical Nurses	36,176	39,432	406,168	10.30	4
5	CNAs & Orderlies	115,961	129,609	866,203	6.68	5
6	CNA Trainees					6
7	Licensed Therapist	7,510	7,928	233,080	29.40	7
8	Rehab/Therapy Aides	9,553	10,456	152,605	14.59	8
9	Activity Director	2,020	2,306	34,876	15.12	9
10	Activity Assistants	6,254	6,749	62,755	9.30	10
11	Social Service Workers	1,853	2,139	46,003	21.51	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	14,453	15,938	157,522	9.88	18
19	Laundry					19
20	Administrator	2,579	2,900	119,954	41.36	20
21	Assistant Administrator	10,028	11,303	304,941	26.98	21
22	Other Administrative	15,074	17,153	223,556	13.03	22
23	Office Manager	1,981	2,203	40,230	18.26	23
24	Clerical	9,655	10,787	130,659	12.11	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)	276,783	306,088	$ 3,461,373 *	$ 11.31	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 Restorative Care # 0048264 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DeShawn Schmidt	Exec Director		$ 78,499
Other Administrative	Business Office		171,142
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 249,641

B. Administrative - Other

Description	Amount
Corporate Allocations	$ 1,217,034
Telephone	30,874
Insurance	10,471
Other Administrative	145,554
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,403,933
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR R Consulting		$ 515
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 515

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 1,899
Unemployment Compensation Insurance	
FICA Taxes	237,912
Employee Health Insurance	347,301
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	103,697
Employee Assistance Program	4,386
Long Term Disability	13,521
Life Insurance	5,805
Other Benefits	98,600
Hospital OH Allocation Adj	
TOTAL (agree to Schedule V, line 22, col.8)	$ 813,121

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	7,032
Dues Ill. Nrsg Home Admin. Assoc.	100
Other Dues/Subscriptions	1,100
Adv and Promotions	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,232

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Education & Travel	5,737
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,737

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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 Restorative Care **#** 0048264 **Report Period Beginning:** 07/01/2011 **Ending:** 06/30/2012

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. $ **5,712** 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.