FOR BHF USE

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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 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: Martin Orwitz **Telephone Number:** (563) 421-4175
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 07/01/2014 to 06/30/2015 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: 07/01/2014 Ending: 06/30/2015

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	83	Skilled (SNF)	92	30,736	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	37	Sheltered Care (SC)	28	13,064	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	5,384	12,128	9,678	27,190	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		8,954		8,954	12
13	DD 16 OR LESS					13
14	TOTALS	5,384	21,082	9,678	36,144	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.52%

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 83 and days of care provided 27,190

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: 06/30/2015 Fiscal Year: 06/30/2015

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

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary			179,852	179,852		179,852		179,852			1
2	Food Purchase		518,434		518,434		518,434	32,310	550,744			2
3	Housekeeping	61,465	22,916	131,897	216,278		216,278		216,278			3
4	Laundry							106,379	106,379			4
5	Heat and Other Utilities			48,314	48,314		48,314		48,314			5
6	Maintenance	28,938	26,550	107,637	163,125		163,125	14,534	177,659			6
7	Other (specify):*							144,250	144,250			7
8	TOTAL General Services	90,403	567,900	467,700	1,126,003		1,126,003	297,473	1,423,476			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,784,063	170,504	380,763	3,335,330		3,335,330	156,939	3,492,269			10
10a	Therapy	750,613	6,715	12,913	770,241		770,241		770,241			10a
11	Activities	86,447	5,263	10,771	102,481		102,481		102,481			11
12	Social Services	63,632	10	1,650	65,292		65,292		65,292			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,684,755	182,492	406,097	4,273,344		4,273,344	156,939	4,430,283			16
	C. General Administration											
17	Administrative	269,361	2,031	1,541,983	1,813,375		1,813,375	(575,191)	1,238,184			17
18	Directors Fees											18
19	Professional Services			67,756	67,756		67,756		67,756			19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses	252,951	8,484	13,580	275,015		275,015	(50,438)	224,577			21
22	Employee Benefits & Payroll Taxes			897,996	897,996		897,996	(515,867)	382,129			22
23	Inservice Training & Education											23
24	Travel and Seminar			369	369		369		369			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			30,342	30,342		30,342	(30,342)				26
27	Other (specify):*											27
28	TOTAL General Administration	522,312	10,515	2,552,026	3,084,853		3,084,853	(1,171,838)	1,913,015			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,297,470	760,907	3,425,823	8,484,200		8,484,200	(717,426)	7,766,774			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:** 07/01/2014 **Ending:** 06/30/2015

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			404,662	404,662		404,662	(140,482)	264,180			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			155,566	155,566		155,566	(155,566)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			560,228	560,228		560,228	(296,048)	264,180			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		323,778		323,778		323,778		323,778			39
40	Barber and Beauty Shops			19,443	19,443		19,443		19,443			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			153,066	153,066		153,066		153,066			42
43	Other (specify):*	142,266	284,525	757,490	1,184,281		1,184,281	630,100	1,814,381			43
44	**TOTAL Special Cost Centers**	142,266	608,303	929,999	1,680,568		1,680,568	630,100	2,310,668			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,439,736	1,369,210	4,916,050	10,724,996		10,724,996	(383,374)	10,341,622			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: 07/01/2014 Ending: 06/30/2015

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				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(55,644)	10		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				10
11	Discounts, Allowances, Rebates & Refunds	(46)	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				28
29	Other-Attach Schedule	(813)	3		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (56,503)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (56,503)		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: 07/01/2014

Ending: 06/30/2015

	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 Restorative Care **#** 0048264 **Report Period Beginning:** 07/01/2014 **Ending:** 06/30/2015

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	32,310	0	0	0	0	0	0	0	0	0	32,310	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	106,379	0	0	0	0	0	0	0	0	0	106,379	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	14,534	0	0	0	0	0	0	0	0	0	14,534	6
7	Other (specify):*	0	144,250	0	0	0	0	0	0	0	0	0	144,250	7
8	**TOTAL General Services**	0	297,473	0	0	0	0	0	0	0	0	0	297,473	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	(55,644)	212,583	0	0	0	0	0	0	0	0	0	156,939	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(55,644)	212,583	0	0	0	0	0	0	0	0	0	156,939	16
	C. General Administration													
17	Administrative	(46)	(575,145)	0	0	0	0	0	0	0	0	0	(575,191)	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	(50,438)	0	0	0	0	0	0	0	0	0	(50,438)	21
22	Employee Benefits & Payroll Taxes	0	(515,867)	0	0	0	0	0	0	0	0	0	(515,867)	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	(30,342)	0	0	0	0	0	0	0	0	0	(30,342)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(46)	(1,171,792)	0	0	0	0	0	0	0	0	0	(1,171,838)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(55,690)	(661,736)	0	0	0	0	0	0	0	0	0	(717,426)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Illini Restorative Care **#** 0048264 **Report Period Beginning:** 07/01/2014 **Ending:** 06/30/2015

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	(140,482)	0	0	0	0	0	0	0	0	0	(140,482)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	(155,566)	0	0	0	0	0	0	0	0	0	(155,566)	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**	0	(296,048)	0	0	0	0	0	0	0	0	0	(296,048)	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	630,100	0	0	0	0	0	0	0	0	0	630,100	43
44	**TOTAL Special Cost Centers**	0	630,100	0	0	0	0	0	0	0	0	0	630,100	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(55,690)	(327,684)	0	0	0	0	0	0	0	0	0	(383,374)	45

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	Silvis	GMC Silvis	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	$ 698,285	GMC Silvis (B Pt I Allocated Cost)	100.00%	$ 730,595	$ 32,310	1
2	V	4	Laundry		GMC Silvis (B Pt I Allocated Cost)	100.00%	106,379	106,379	2
3	V	6	Plant Op/Maintenance		GMC Silvis (B Pt I Allocated Cost)	100.00%	14,534	14,534	3
4	V	7	Cafeteria		GMC Silvis (B Pt I Allocated Cost)	100.00%	144,250	144,250	4
5	V	10	Medical Records & Nrsg Adm		GMC Silvis (B Pt I Allocated Cost)	100.00%	212,583	212,583	5
6	V	17	Administrative & General	1,881,130	GMC Silvis (B Pt I Allocated Cost)	100.00%	1,305,985	(575,145)	6
7	V	21	Clerical & General Office Exp	72,967	GMC Silvis (B Pt I Allocated Cost)	100.00%	22,529	(50,438)	7
8	V	22	Employee Benefits	842,547	GMC Silvis (B Pt I Allocated Cost)	100.00%	326,680	(515,867)	8
9	V	26	Insurance-Prop.Liab.Malpr	30,342	GMC Silvis (B Pt I Allocated Cost)	100.00%		(30,342)	9
10	V	30	CRC Bldgs & Fixt-Depr	404,661	GMC Silvis (B Pt I Allocated Cost)	100.00%	264,179	(140,482)	10
11	V	32	CRC Bldgs & Fixt-Interest	155,566	GMC Silvis (B Pt I Allocated Cost)	100.00%		(155,566)	11
12	V	43	Crosstown Square	620,771	GMC Silvis (B Pt I Allocated Cost)	100.00%	1,250,871	630,100	12
13	V								13
14	Total			$ 4,706,269			$ 4,378,585	$ * (327,684)	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: 07/01/2014 Ending: 06/30/2015

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	NOT APPLICABLE							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

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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: 07/01/2014 Ending: 6/30/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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		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										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

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Quad City Bank & Trust		X	Mortgage	$85,370.00	06/28/06	$ 11,000,000	$	07/08/11	0.0690	$	1
2	GMC Silvis	X		Mortgage	$90,699.35	06/02/10	8,958,390	4,850,607	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	$ 4,850,607			$	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	$ 4,850,607			$	15

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

*** 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:** 07/01/2014 **Ending:** 06/30/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 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 2015 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:			
	2010	N/A	8
	2011	N/A	9
	2012	N/A	10
	2013	N/A	11
	2014	N/A	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 07/01/2014 Ending: 06/30/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 220,901 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 [ ] 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	220,901	1993 & 1999	$ 33,442	1
2					2
3	TOTALS	220,901		$ 33,442	3

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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		$ 672,717	$ 16,818	40	$ 16,818	$	$ 407,834	4
5			2000		5,239,215	130,980	40	130,980		1,946,963	5
6											6
7											7
8											8
	Improvement Type**										
9	Legal & Professional			1991	89,731	2,243	40	2,243		54,400	9
10	Painting & Wallpaper			1991	2,032		5			2,032	10
11	Carpet & Tile			1991	1,622		5			1,622	11
12	Field Tests			1991	1,547	39	40	39		938	12
13	Electrical Supplies			1991	396		10			396	13
14	3 Wall Pack Lights			1991	3,472		10			3,472	14
15	Time & Material Work			1991	17,753	444	40	444		10,763	15
16	Kitchen Plan			1991	1,025	26	40	26		621	16
17	Co#15-Fire Exting&Cabinet			1991	1,106		15			1,106	17
18	Co#16,17-Paint/Whirlpool			1991	2,590		10			2,590	18
19	Co#18-Gutter & Downspouts			1991	3,929		15			3,929	19
20	Co19,20,21,24,25,26,27,28(Htg/Vent/AC)			1991	27,371	684	40	684		16,593	20
21	Co29-Pipe Recepticals,Ect			1991	7,746	310	25	310		7,513	21
22	Co#23-Kitchen & Lounge			1991	40,623	1,016	40	1,016		24,628	22
23	Co#30-City Walk			1991	323		10			323	23
24	Co#33-Copper Wire			1991	3,981		20			3,981	24
25	Co#31-2 Exit Light			1991	148		10			148	25
26	Co#32-Smoke Detect/Wiring			1991	1,605		10			1,605	26
27	Co#1-7 Sewer Line&Overbed			1991	18,770		20			18,770	27
28	Co#9-Elevator Auto Ret Sy			1991	1,042		20			1,042	28
29	Co#8-14 (Exct9) Lights, Walk			1991	13,230		10			13,230	29
30	Est Nailers, Wood Trusses			1991	31,871		15			31,871	30
31	Cabin, Toilets, Doors, Handr			1991	57,912		15			57,912	31
32	Grade Insulation			1991	3,257		15			3,257	32
33	Roof System			1991	36,118		10			36,118	33
34	Sheet Metal			1991	3,843		20			3,843	34
35	Wood Doors&Frames; Hardwar			1991	53,541		20			53,541	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: 07/01/2014 Ending: 06/30/2015

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	Metal Windows	1991	$ 13,134	$	20	$	$	$ 13,134	37
38	Alum Entrances&Storefront	1991	7,608		20			7,608	38
39	Ceramic Tile	1991	3,575		20			3,575	39
40	Acoustic Ceilings	1991	23,090		15			23,090	40
41	Resil Floor&Base, Stair Tr	1991	11,340		10			11,340	41
42	Paint & Wall Covering	1991	32,200		5			32,200	42
43	Carpet	1991	18,550		5			18,550	43
44	Plumbing, Sprinkler Work	1991	211,741		20			211,741	44
45	Heating	1991	157,820		17			157,820	45
46	Air Conditioning	1991	133,565		17			133,565	46
47	Electrical	1991	128,975		20			128,975	47
48	Plumbing&Electrical Util	1991	44,800		20			44,800	48
49	Fans	1991	2,017		15			2,017	49
50	Lockers, Toilet Accessorie	1991	5,747		15			5,747	50
51	Cabinets, Casework	1991	23,231		20			23,231	51
52	Elevators	1991	13,665		20			13,665	52
53	Landscaping	1991	1,050		10			1,050	53
54	Concrete Curb&Walk, Aph Rd	1991	27,738		15			27,738	54
55	Landscaping	1991	9,100		10			9,100	55
56	Sign Electrical Feed	1991	1,209		20			1,209	56
57	Parking Curbs	1991	577		10			577	57
58	Sod	1991	1,945		10			1,945	58
59	Dining Room Sound System	1991	1,561		5			1,561	59
60	1 Sign 3'X10' Single Side	1991	3,826		12			3,826	60
61	Signs	1992	503		12			503	61
62	Nurses Station	1992	457		10			457	62
63	Nurse Call System	1992	2,043		15			2,043	63
64	Handrail and Door	1992	1,470		15			1,470	64
65	Door Access	1992	856		10			856	65
66	Cntrl Domestic Water Heat	1992	466		10			466	66
67	Wallpaper & Carpeting	1992	3,326		5			3,326	67
68	Smoke Door Holders	1992	779		10			779	68
69	Chandelier	1992	492		10			492	69
70	TOTAL (lines 4 thru 69)		$ 7,226,972	$ 152,560		$ 152,560	$	$ 3,599,497	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: 07/01/2014 Ending: 06/30/2015

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		$ 7,226,972	$ 152,560		$ 152,560	$	$ 3,599,497	1
2	Alarm System	1992	587		15			587	2
3	Carpet	1992	438		5			438	3
4	Vinyl	1992	578		20			578	4
5	Crosstown Sign	1993	1,305		12			1,305	5
6	New Seeding/Mulch	1993	5,131		10			5,131	6
7	Circuit Panel, A/C Outlet	1993	930		10			930	7
8	Wanderguard Depart Alert	1993	3,117		10			3,117	8
9	Air Condition Installation	1994	498		10			498	9
10	Cs Carpet Apt #117	1994	690		5			690	10
11	Repair Sidewalk	1994	1,874		15			1,874	11
12	Handrails - Irc	1994	5,358		15			5,358	12
13	Window Coverings-Pt Area	1994	1,467		5			1,467	13
14	Sidewalk	1995	710		15			710	14
15	Tile & Base for Hallway	1995	2,183		10			2,183	15
16	Tile for Irc Hallway	1995	1,004		10			1,004	16
17	Irc Hall Tile Repair	1995	694		10			694	17
18	P.T. Utility Study	1995	142,758		15			142,758	18
19	Emerson Air Conditioner	1995	594		10			594	19
20	Drapes-Employee Lounge	1995	1,464		5			1,464	20
21	190 Gal Verticl Asme Tank	1996	2,650		10			2,650	21
22	Directory Board For Wall	1996	797		10			797	22
23	Carpet Apts 240 & 249	1996	1,440		5			1,440	23
24	Hot Water Tank - Labor	1996	1,749		10			1,749	24
25	Major Repairs Irc Boiler	1996	9,872		5			9,872	25
26	Parking Lot 4 Repairs-Irc	1996	3,561		8			3,561	26
27	Remodel Irc Nurse Station	1997	3,340		15			3,340	27
28	Cabinets/Storage-Util Rm	1997	4,103		15			4,103	28
29	Air Compressor For Chillr	1997	14,196		15			14,196	29
30	Double Egress Wood Doors	1998	2,756		15			2,756	30
31	Lock Sets Mastered To Key	1998	2,642		5			2,642	31
32	Landscaping-Irc	1998	2,176		10			2,176	32
33	Carpet Lobby & Office Areas	1998	3,123		5			3,123	33
34	TOTAL (lines 1 thru 33)		$ 7,450,757	$ 152,560		$ 152,560	$	$ 3,823,282	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: 07/01/2014 Ending: 06/30/2015

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		$ 7,450,757	$ 152,560		$ 152,560	$	$ 3,823,282	1
2	Tie-In Piping Hot Water To Irc	1998	1,766	88	20	88		1,457	2
3	VPI Base & Ceramic Tile	1999	1,385		10			1,385	3
4	Wood Replace Doors-Irc 4 Rooms	1999	1,308	44	15	44		1,308	4
5	4"" Sprinkler	2000	18,675	747	25	747		11,578	5
6	Data Voice Wiring-SC	2000	31,453		10			31,453	6
7	Door Alarm-Sheltered Care	2000	2,211		10			2,211	7
8	Analog Message-Sheltered Care	2000	2,693		10			2,693	8
9	Air Cond/Handling Unit	2001	2,187		10			2,187	9
10	Irc Roof Hatches	2001	2,420		10			2,420	10
11	Nurse Call System-Sc	2001	6,498		10			6,498	11
12	Kitchen Cabinets-Sc	2001	4,077	272	15	272		3,941	12
13	Door And Door Closers Exam Rm	2001	1,524	102	15	102		1,473	13
14	Paint Wallpaper Carpet, Act	2001	1,926		5			1,926	14
15	Carpentry Patient Room Showers	2001	9,326	622	15	622		9,015	15
16	Irc Boiler Stack	2001	14,750	738	20	738		10,694	16
17	Pa System Irc Dining Room	2001	1,682		10			1,682	17
18	Concrete Replacement	2001	2,239	149	15	149		2,164	18
19	Door Wooden Irc	2001	1,465	98	15	98		1,319	19
20	Irc Wall Hydrants	2002	1,354		10			1,354	20
21	Irc Wanderguard Relocation	2002	3,122		10			3,122	21
22	Medicare Rooms Wall Guards	2002	772		10			772	22
23	Ahu Valve Control Upgrade	2002	3,328		10			3,328	23
24	Irc Cooling Unit Controls	2002	4,567		10			4,567	24
25	Irc Bedpan Washers	2002	2,923	195	15	195		2,630	25
26	Switchboard Cable Irc	2002	4,831		10			4,831	26
27	Boiler Fair Over Controls	2002	1,905		10			1,905	27
28	Irc Carpet Hallway	2002	10,072		5			10,072	28
29	Asphalt Parking Log-Nw Area	2002	44,394		8			44,394	29
30	Parking Lot Lights Nw Area	2002	9,535		10			9,535	30
31	Double Egress Door Replacement	2002	4,342	217	20	217		2,931	31
32	Bronze Circulating Pump	2003	1,937		10			1,937	32
33	Security System	2003	6,267		10			6,267	33
34	TOTAL (lines 1 thru 33)		$ 7,657,691	$ 155,832		$ 155,832	$	$ 4,016,331	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: 07/01/2014 Ending: 06/30/2015

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 12C, Carried Forward		$ 7,657,691	$ 155,832		$ 155,832	$	$ 4,016,331	1
2	IRC Loading Dock	2003	97,613	3,905	25	3,905		48,807	2
3	Air Conditioning Unit	2003	2,755		7			2,755	3
4	IRC Door Alarm	2003	5,792		10			5,792	4
5	Canopy	2003	2,275	152	15	152		1,744	5
6	Architect Fees	2004	41,400	1,035	40	1,035		11,903	6
7	Blue Prints PT	2004	36	1	40	1		10	7
8	PT Construction	2004	80,180	2,005	40	2,005		23,052	8
9	PT Construction	2004	93,098	2,327	40	2,327		26,766	9
10	Wallcoverings	2004	490		5			490	10
11	Architect Fees IRC Laundry	2004	7,056	176	40	176		2,029	11
12	Blue Prints IRC Laundry	2004	122	3	40	3		35	12
13	Construction IRC Laundry	2004	24,446	611	40	611		7,028	13
14	Contact Services IRC Laundry	2004	60,362	1,509	40	1,509		17,354	14
15	rvs Arch Fees Already Cap	2004	(1,655)	(41)	40	(41)		(476)	15
16	Blue Prints IRC Laund Rvs	2004	(122)	(3)	40	(3)		(35)	16
17	Contract Serv IRC Laun Rvs	2004	(3,023)	(76)	40	(76)		(869)	17
18	Air Handling IRC Laundry	2004	19,065	953	20	953		10,962	18
19	Rvs Air Handling Cap FY03	2004	(19,065)	(953)	20	(953)		(10,962)	19
20	AIR/DIRT SEPARATOR	2004	4,905	245	10	245		4,905	20
21	BOILER REPLACEMENT DEAERATOR	2005	24,668	1,774	15	1,774		16,684	21
22	Roof	2005	51,860	5,186	10	5,186		49,267	22
23	Acuator Controls	2005	4,092	205	20	205		1,944	23
24	LANDSCAPING	2005	2,511	251	10	251		2,386	24
25	CONDUIT & WIRING	2005	1,539	77	20	77		731	25
26	CONSTRUCTION	2005	199,131	19,913	10	19,913		189,175	26
27	DESIGN FEES	2005	15,555	1,556	10	1,556		14,777	27
28	Valve Replacements	2006	12,432	622	20	622		5,905	28
29	DESIGN FEES	2006	1,601	160	10	160		1,521	29
30	HOLLOW METAL DOORS	2006	10,987	549	20	549		5,219	30
31	Drapes (Fabric & Sheer)	2006	2,304		5			2,304	31
32	Electric Switch Gear	2006	3,719	248	15	248		2,107	32
33	IRC Boiler Tank	2008	3,373	337	10	337		2,530	33
34	TOTAL (lines 1 thru 33)		$ 8,407,193	$ 198,559		$ 198,559	$	$ 4,462,171	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: 07/01/2014 Ending: 06/30/2015

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 12D, Carried Forward		$ 8,407,193	$ 198,559		$ 198,559	$	$ 4,462,171	1
2	Repair Sidewalk LSC Survey	2008	2,257	150	15	150		1,129	2
3	Door Hold - Magnetic	2008	1,404	140	10	140		912	3
4	Nurse Call System	2008	54,966	5,497	10	5,497		35,728	4
5	Air Conditioning/Cooling	2008	4,050		5			4,050	5
6	Boiler Replacement	2008	432,708	21,635	20	21,635		140,630	6
7	IRC Boiler Replacement	2008	99,083	5,828	17	5,828		37,885	7
8	Replace Nurse Call System	2008	60,202	6,020	10	6,020		39,131	8
9	Fire Damper Doors LSC Survey	2008	7,877	394	20	394		2,560	9
10	Replace Asphalt Entry Drive	2008	23,800	1,587	15	1,587		10,313	10
11	Replace Corridor Doors	2009	15,509	1,034	15	1,034		6,720	11
12	Magnetic Door Holder	2009	1,334	133	10	133		867	12
13	Replace Fire Alarm Panel	2009	62,446	6,245	10	6,245		40,590	13
14	Domestic Hot Water Pumps	2009	56,488	3,766	15	3,766		20,712	14
15	Replace Chiller Module IRC N	2009	14,723	1,472	10	1,472		8,097	15
16	Sprinkler System Internal	2010	50,187	2,007	25	2,007		11,041	16
17	Remodel 8 Private Rooms	2010	44,255	2,950	15	2,950		16,227	17
18	Remodel 8 Private Rooms	2010	7,888	789	5	789		7,888	18
19	Emerg Power IRC Pt Rooms	2010	15,721	1,048	15	1,048		5,764	19
20	Replace Old Roof Section - IRC	2011	122,994	12,299	10	12,299		43,048	20
21	Storm Sewer Repair	2011	4,434	177	25	177		621	21
22	Air Conditioner Replace IRC	2011	5,265	351	15	351		1,229	22
23	Upgrade Entrances to Handicap	2011	10,023	1,002	10	1,002		3,508	23
24	Handicap Door Access	2011	2,867	287	10	287		1,003	24
25	Lighting for IRC	2012	10,519	1,052	10	1,052		3,681	25
26	Add AC Units to Cool Offices	2012	13,450	1,345	10	1,345		4,708	26
27	Feed Wiring for New Sign	2012	1,250	63	20	63		219	27
28	New Freestanding Sign	2012	5,905	591	10	591		2,067	28
29	IRC Patient Room Upgrades	2012	25,676	2,568	10	2,568		6,419	29
30	IRC Patient Room Upgrades	2012	11,106	740	15	740		1,851	30
31	IRC Patient Room Upgrades	2012	191,619	9,581	20	9,581		23,952	31
32	Sink for Soiled Utility Room	2012	9,165	458	20	458		1,146	32
33	IRC Patient Room Upgrades	2012	8,362	1,672	5	1,672		4,181	33
34	TOTAL (lines 1 thru 33)		$ 9,784,726	$ 291,440		$ 291,440	$	$ 4,950,048	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: 07/01/2014 Ending: 06/30/2015

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 12E, Carried Forward		$ 9,784,726	$ 291,440		$ 291,440	$	$ 4,950,048	1
2	Resurface IRC Parking Lot	2012	16,117	2,015	8	2,015		5,037	2
3	Therapy Equipment IRC	2012	2,167	144	15	144		361	3
4	Replacement Sidewalks	2012	15,535	1,036	15	1,036		2,589	4
5	Renovation of Shelter/Medicare	2013	6,097	1,219	5	1,219		3,049	5
6	Renovation of Shelter/Medicare	2013	178,023	17,802	10	17,802		44,506	6
7	Renovation of Bath and Station	2013	2,139	214	10	214		535	7
8	Replace Failed Boiler IRC N	2013	31,353	1,568	20	1,568		2,351	8
9	Keypad Release Lock	2013	6,776	1,355	5	1,355		2,033	9
10	Replace Failing Boiler IRC	2015	31,118	778	20	778		778	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	TOTAL (lines 1 thru 33)		$ 10,074,051	$ 317,571		$ 317,571	$	$ 5,011,287	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: 07/01/2014 Ending: 06/30/2015

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	$ 772,385	$ 89,277	$ 89,277	$		$ 460,494	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	652,033					652,033	73
74								74
75	TOTALS	$ 1,424,418	$ 89,277	$ 89,277	$		$ 1,112,527	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)	$ 11,531,911	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 406,848	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 406,848	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)	$ 6,123,814	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: 07/01/2014 Ending: 06/30/2015

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. 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.	/2016	$
13.	/2017	$
14.	/2018	$

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			$	$	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: 07/01/2014 Ending: 06/30/2015

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.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
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				323,739		323,739	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			$		$	$ 323,739		$ 323,739	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2015 (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	$ 355,350	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	808,742		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	4,653		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,168,745	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	411,960		13
14	Buildings, at Historical Cost	16,417,640		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	(300,627)		16
17	Accumulated Depreciation (book methods)	(10,050,048)		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	57,723		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,536,648	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,705,393	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 403,845	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	114,219		29
30	Accrued Salaries Payable	963,656		30
31	Accrued Taxes Payable (excluding real estate taxes)			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	404,682		36
37	Other Accrued Expenses	192,611		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,079,013	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,040,094		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Other Accrued Pension Cost	3,939,659		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 7,979,753	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,058,766	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,353,373)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,705,393	$	48

*(See instructions.)

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,442,389	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,442,389	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(759,657)	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) **Interest Income**	3,985	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (755,672)	17
	B. Transfers (Itemize):		
18	**Equity Transfers**	(4,040,090)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (4,040,090)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,353,373)	24 *

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

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	$ 13,710,750	1
2	Discounts and Allowances for all Levels	(3,848,934)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,861,816	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	47,833	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	55,644	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	46	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)**	$ 103,523	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,965,339	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,126,003	31
32	Health Care	4,273,344	32
33	General Administration	3,084,853	33
	B. Capital Expense		
34	Ownership	560,228	34
	C. Ancillary Expense		
35	Special Cost Centers	1,680,568	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,724,996	40
41	**Income before Income Taxes (line 30 minus line 40)****	(759,657)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (759,657)	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: 07/01/2014 Ending: 06/30/2015

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	1,244	1,415	$ 51,400	$ 36.33	1
2	Assistant Director of Nursing					2
3	Registered Nurses	35,749	38,644	1,031,748	26.70	3
4	Licensed Practical Nurses	19,994	22,234	409,663	18.43	4
5	CNAs & Orderlies	88,561	95,020	1,212,389	12.76	5
6	CNA Trainees					6
7	Licensed Therapist	17,486	19,309	620,702	32.15	7
8	Rehab/Therapy Aides	11,960	13,513	250,412	18.53	8
9	Activity Director					9
10	Activity Assistants	7,048	7,894	104,349	13.22	10
11	Social Service Workers	2,651	2,938	65,695	22.36	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,537	2,543	46,548	18.30	17
18	Housekeepers	5,711	6,541	79,982	12.23	18
19	Laundry					19
20	Administrator	3,490	3,770	231,241	61.34	20
21	Assistant Administrator					21
22	Other Administrative	2,194	2,425	61,148	25.22	22
23	Office Manager					23
24	Clerical	14,730	15,960	274,461	17.20	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)	213,355	232,206	$ 4,439,738 *	$ 19.12	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: 07/01/2014 Ending: 06/30/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Glenwood Roebuck	Exec Director		$ 90,625
Michael Moore	Administator		91,556
DeShawn Schmidt	Administator		42,165
Debra Slater	Administator		1,192
Kelli Hutchison	Asst, Admin		17,586
Brenda Yanez	Asst, Admin		26,237
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 269,361

B. Administrative - Other

Description	Amount
Corporate Allocations	$ 1,452,869
Dues	4,023
Other Administrative	85,091
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 1,541,983

C. Professional Services

Vendor/Payee	Type	Amount
Health Dimensions Con	Nursing Home Operations	$ 41,667
Wescom Solutions	Other	20,446
Shive Hattery	Other	5,208
Ramirez Consulting	Other	300
FR R Consulting	Other	135
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 67,756

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 19,231
Unemployment Compensation Insurance	11,433
FICA Taxes	311,720
Employee Health Insurance	253,139
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	157,053
Employee Assistance Program	5,726
Long Term Disability	15,296
Life Insurance	4,812
Other Benefits	119,586
TOTAL (agree to Schedule V, line 22, col.8)	$ 897,996

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	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Education & Travel	369
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 369

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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:** 07/01/2014 **Ending:** 06/30/2015

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. **IL Council Long Term Care $4,133**

(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. $ **8,819** 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. $ **153,066**
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 out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.