FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 07/01/2015 to 06/30/2016 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: 07/01/2015 Ending: 06/30/2016

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	92	Skilled (SNF)	92	33,580	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	28	Sheltered Care (SC)	28	10,220	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	6,377	9,774	9,487	25,638	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		5,621		5,621	12
13	DD 16 OR LESS					13
14	TOTALS	6,377	15,395	9,487	31,259	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.37%

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 92 and days of care provided 25,638

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: 06/30/2016 Fiscal Year: 06/30/2016

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

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary		1,556	519,629	521,185		521,185		521,185			1
2	Food Purchase		263,678		263,678		263,678		263,678			2
3	Housekeeping		49,652	162,732	212,384		212,384		212,384			3
4	Laundry							79,896	79,896			4
5	Heat and Other Utilities			50,870	50,870		50,870		50,870			5
6	Maintenance	10,444	57,201	89,943	157,588		157,588	13,598	171,186			6
7	Other (specify):*											7
8	**TOTAL General Services**	10,444	372,086	823,174	1,205,703		1,205,703	93,494	1,299,198			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,974,870	204,259	425,504	3,604,632		3,604,632	58,863	3,663,495			10
10a	Therapy	726,678	6,314	24,585	757,577		757,577	(55,644)	701,933			10a
11	Activities	68,361	3,364	8,195	79,920		79,920		79,920			11
12	Social Services	69,833		1,136	70,969		70,969		70,969			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,839,742	213,937	459,420	4,513,098		4,513,098	3,219	4,516,318			16
	C. General Administration											
17	Administrative	200,189	6,746	1,511,944	1,718,879		1,718,879	(538,543)	1,180,336			17
18	Directors Fees											18
19	Professional Services			29,619	29,619		29,619		29,619			19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses	178,168	8,172	16,381	202,721		202,721	(7,096)	195,624			21
22	Employee Benefits & Payroll Taxes			874,854	874,854		874,854	(251,988)	622,866			22
23	Inservice Training & Education											23
24	Travel and Seminar			932	932		932		932			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			16,239	16,239		16,239	(16,239)				26
27	Other (specify):*											27
28	**TOTAL General Administration**	378,357	14,918	2,449,969	2,843,243		2,843,243	(813,866)	2,029,377			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,228,542	600,940	3,732,562	8,562,045		8,562,045	(717,152)	7,844,892			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:** 07/01/2015 **Ending:** 06/30/2016

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			373,425	373,425		373,425	(95,083)	278,342			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			129,534	129,534		129,534	(129,534)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			502,959	502,959		502,959	(224,617)	278,342			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		338,062		338,062		338,062		338,062			39
40	Barber and Beauty Shops			17,470	17,470		17,470		17,470			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			147,306	147,306		147,306		147,306			42
43	Other (specify):* **Cross Town**	138,934	184,447	824,784	1,148,166		1,148,166	(9,737)	1,138,428			43
44	**TOTAL Special Cost Centers**	138,934	522,510	989,561	1,651,004		1,651,004	(9,737)	1,641,267			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,367,476	1,123,450	5,225,082	10,716,009		10,716,009	(951,507)	9,764,501			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: 07/01/2015 Ending: 06/30/2016

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)	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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				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	(797)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (56,441)		$	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))**	$ (56,441)		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: 07/01/2015

Ending: 06/30/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Distribution - Miscellaneous Revenue	$ (600)	17	1
2	Sheltered Beds - Outreach Revenue	233	10	2
3	Nursing Floor - IRC Medicare - Miscellaneous Revenue	(430)	10	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
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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**	(797)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	79,896	0	0	0	0	0	0	0	0	0	79,896	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	13,598	0	0	0	0	0	0	0	0	0	13,598	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	93,494	0	0	0	0	0	0	0	0	0	93,494	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	(197)	59,060	0	0	0	0	0	0	0	0	0	58,863	10
10a	Therapy	(55,644)	0	0	0	0	0	0	0	0	0	0	(55,644)	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**	(55,841)	59,060	0	0	0	0	0	0	0	0	0	3,219	16
	C. General Administration													
17	Administrative	(600)	(537,943)	0	0	0	0	0	0	0	0	0	(538,543)	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	(7,096)	0	0	0	0	0	0	0	0	0	(7,096)	21
22	Employee Benefits & Payroll Taxes	0	(251,988)	0	0	0	0	0	0	0	0	0	(251,988)	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	(16,239)	0	0	0	0	0	0	0	0	0	(16,239)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(600)	(813,266)	0	0	0	0	0	0	0	0	0	(813,866)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(56,441)	(660,712)	0	0	0	0	0	0	0	0	0	(717,152)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Illini Restorative Care # 0048264 **Report Period Beginning:** 07/01/2015 **Ending:** 06/30/2016

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	(95,083)	0	0	0	0	0	0	0	0	0	(95,083)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	(129,534)	0	0	0	0	0	0	0	0	0	(129,534)	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	(224,617)	0	0	0	0	0	0	0	0	0	(224,617)	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	(9,737)	0	0	0	0	0	0	0	0	0	(9,737)	43
44	**TOTAL Special Cost Centers**	0	(9,737)	0	0	0	0	0	0	0	0	0	(9,737)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(56,441)	(895,066)	0	0	0	0	0	0	0	0	0	(951,507)	45

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	4	Laundry	$	GMC Silvis (B Pt I Allocated Cost)	100.00%	$ 79,896	$ 79,896	1
2	V	6	Plant Op/Maintenance		GMC Silvis (B Pt I Allocated Cost)	100.00%	13,598	13,598	2
3	V	10	Medical records		GMC Silvis (B Pt I Allocated Cost)	100.00%	59,060	59,060	3
4	V	17	Administrative & General	1,748,498	GMC Silvis (B Pt I Allocated Cost)	100.00%	1,210,555	(537,943)	4
5	V	21	Clerical & General Office Expenses	41,617	GMC Silvis (B Pt I Allocated Cost)	100.00%	34,521	(7,096)	5
6	V	22	Employee Benefits	581,145	GMC Silvis (B Pt I Allocated Cost)	100.00%	329,157	(251,988)	6
7	V	26	Insurance-Prop.Liab.Malpractice	16,239	GMC Silvis (B Pt I Allocated Cost)	100.00%		(16,239)	7
8	V	30	CRC Bldgs & Fixt-Depr	373,425	GMC Silvis (B Pt I Allocated Cost)	100.00%	278,342	(95,083)	8
9	V	32	CRC Bldgs & Fixt-Interest	129,534	GMC Silvis (B Pt I Allocated Cost)	100.00%		(129,534)	9
10	V	43	Crosstown Square	207,085	GMC Silvis (B Pt I Allocated Cost)	100.00%	197,348	(9,737)	10
11	V								11
12	V								12
13	V								13
14	Total			$ 3,097,543			$ 2,202,477	$ * (895,066)	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: 07/01/2015 Ending: 06/30/2016

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	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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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: 07/01/2015 Ending: 6/30/2016

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: 07/01/2015 Ending: 06/30/2016

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	$	07/08/11	0.0690	$	1
2	GMC Silvis	X		Mortgage	$90,699.35	06/02/10	8,958,390	3,939,659	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	$ 3,939,659			$	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	$ 3,939,659			$	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:** 07/01/2015 **Ending:** 06/30/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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 2016 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:		
2011	N/A	8
2012	N/A	9
2013	N/A	10
2014	N/A	11
2015	N/A	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 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 2015 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 2015.

	(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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 07/01/2015 Ending: 06/30/2016

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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	$ 57,723	1
2					2
3	TOTALS	220,901		$ 57,723	3

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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			1991		$ 584,661	$ 14,617	40	$ 14,617	$	$	4
5			2000		5,435,418	135,885	40	135,885			5
6											6
7											7
8											8
	Improvement Type**										
9	Replace Old Roof Section - IRC			2011	122,994	12,299	10	12,299		55,347	9
10	Storm Sewer Repair			2011	4,434	177	25	177		798	10
11	Sign Electrical Feed			1991	1,209		20			1,209	11
12	Carpet			1992	438		5			438	12
13	IRC Loading Dock			2003	97,613	3,905	25	3,905		52,711	13
14	Legal & Professional			1991	89,731	2,243	40	2,243		56,643	14
15	Painting & Wallpaper			1991	2,032		5			2,032	15
16	Carpet & Tile			1991	1,622		5			1,622	16
17	Field Tests			1991	1,547	39	40	39		976	17
18	Electrical Supplies			1991	396		10			396	18
19	3 Wall Pack Lights			1991	3,472		10			3,472	19
20	Time & Material Work			1991	17,753	444	40	444		11,206	20
21	Kitchen Plan			1991	1,025	26	40	26		647	21
22	Co#15-Fire Exting&Cabinet			1991	1,106		15			1,106	22
23	Co#16,17-Paint/Whirlpool			1991	2,590		10			2,590	23
24	Co#18-Gutter & Downspouts			1991	3,929		15			3,929	24
25	Co19,20,21,24,25,26,27,28			1991	27,371	684	40	684		17,278	25
26	Co29-Pipe Recepticals,Ect			1991	7,746	232	25	232		7,746	26
27	Co#23-Kitchen & Lounge			1991	40,623	1,016	40	1,016		25,644	27
28	Co#30 - City Walk			1991	323		10			323	28
29	Co#33 - Copper Wire			1991	3,981		20			3,981	29
30	Co#31 - 2 Exit Light			1991	148		10			148	30
31	Co#32-Smoke Detect/Wiring			1991	1,605		10			1,605	31
32	Co#1-7 Sewer Line&Overbed			1991	18,770		20			18,770	32
33	Co#9-Elevator Auto Ret Sy			1991	1,042		20			1,042	33
34	Co#8-14(Exct9)Lights,Walk			1991	13,230		10			13,230	34
35	Est Nailers,Wood Trusses			1991	31,871		15			31,871	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: 07/01/2015 Ending: 06/30/2016

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	Cabin,Toilets,Doors,Handr	1991	$ 57,912	$	15	$	$	$ 57,912	37
38	Grade Insulation	1991	3,257		15			3,257	38
39	Roof System,Asphalt Shing	1991	36,118		10			36,118	39
40	Sheet Metal	1991	3,843		20			3,843	40
41	Wood Doors&Frames;Hardwar	1991	53,541		20			53,541	41
42	Metal Windows	1991	13,134		20			13,134	42
43	Alum Entrances&Storefront	1991	7,608		20			7,608	43
44	Ceramic Tile	1991	3,575		20			3,575	44
45	Acoustic Ceilings	1991	23,090		15			23,090	45
46	Resil Floor&Base,Stair Tr	1991	11,340		10			11,340	46
47	Paint & Wall Covering	1991	32,200		5			32,200	47
48	Carpet	1991	18,550		5			18,550	48
49	Plumbing,Sprinkler Work	1991	211,741		20			211,741	49
50	Heating	1991	157,820		17			157,820	50
51	Air Conditioning	1991	133,565		17			133,565	51
52	Electrical	1991	128,975		20			128,975	52
53	Plumbing&Electrical Util	1991	44,800		20			44,800	53
54	Building	1992	88,055	2,201	40	2,201		55,585	54
55	Wallpaper & Carpeting	1993	3,326		5			3,326	55
56	Circuit Panel, A/C Outlet	1994	930		10			930	56
57	Handrails - Irc	1995	5,358		15			5,358	57
58	Tile & Base For Hallway	1995	2,183		10			2,183	58
59	Tile For Irc Hallway	1995	1,004		10			1,004	59
60	Irc Hall Tile Repair	1995	694		10			694	60
61	P.T. Utility Study	1997	142,758		15			142,758	61
62	Air Compressor For Chillr	1998	14,196		15			14,196	62
63	Carpet Lobby & Office Areas	1998	3,123		5			3,123	63
64	Tie-In Piping Hot Water To Irc	1999	1,766	88	20	88		1,545	64
65	VPI Base & Ceramic Tile	2001	1,385		10			1,385	65
66	Irc Roof Hatches	2001	2,420		10			2,420	66
67	Door And Door Closers Exam Rm	2001	1,524	51	15	51		1,524	67
68	Paint Wallpaper Carpet, Act	2001	1,926		5			1,926	68
69	Carpentry Patient Room Showers	2002	9,326	311	15	311		9,326	69
70	TOTAL (lines 4 thru 69)		$ 7,739,724	$ 174,218		$ 174,218	$	$ 1,505,113	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: 07/01/2015 Ending: 06/30/2016

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		$ 7,739,724	$ 174,218		$ 174,218	$	$ 1,505,113	1
2	Irc Wall Hydrants	2002	1,354		10			1,354	2
3	Irc Wanderguard Relocation	2002	3,122		10			3,122	3
4	Medicare Rooms Wall Guards	2002	772		10			772	4
5	Ahu Valve Control Upgrade	2002	3,328		10			3,328	5
6	Irc Cooling Unit Controls	2002	4,567		10			4,567	6
7	Irc Carpet Hallway	2002	10,072		5			10,072	7
8	Double Egress Door Replacement	2003	4,342	217	20	217		3,148	8
9	Security System	2001	6,267		10			6,267	9
10	Sheltered Care Addition	1992	(196,204)	(4,905)	40	(4,905)		(73,576)	10
11	Vinyl	1994	578		20			578	11
12	Chandelier	2004	492		10			492	12
13	Air Condition Installatio	2004	498		10			498	13
14	Architect Fees	2004	41,400	1,035	40	1,035		12,938	14
15	Blue Prints PT	2004	36	1	40	1		11	15
16	PT Construction	2004	80,180	2,005	40	2,005		25,056	16
17	PT Construction	2005	93,098	2,327	40	2,327		29,093	17
18	Wallcoverings	2004	490		5			490	18
19	BOILER REPLACEMENT DEAERATOR	2005	24,668	1,774	15	1,774		18,458	19
20	AIR/DIRT SEPARATOR	2005	4,905		10			4,905	20
21	Roof	2006	51,860	2,593	10	2,593		51,860	21
22	Acuator Controls	2005	4,092	205	20	205		2,148	22
23	Valve Replacements	2005	12,432	622	20	622		6,527	23
24	CONDUIT & WIRING	2005	1,539	77	20	77		808	24
25	CONSTRUCTION	2006	199,131	9,957	10	9,957		199,131	25
26	DESIGN FEES	2006	15,555	778	10	778		15,555	26
27	DESIGN FEES	2009	1,601	80	10	80		1,601	27
28	HOLLOW METAL DOORS	2004	10,987	549	20	549		5,768	28
29	Replace Corridor Doors	2004	15,509	1,034	15	1,034		7,754	29
30	Architect Fees IRC Laundry	2004	7,056	176	40	176		2,205	30
31	Blue Prints IRC Laundry	2004	122	3	40	3		38	31
32	Construction IRC Laundry	2004	24,446	611	40	611		7,639	32
33	Contact Services IRC Laundry	2004	60,362	1,509	40	1,509		18,863	33
34	TOTAL (lines 1 thru 33)		$ 8,228,381	$ 194,866		$ 194,866	$	$ 1,876,584	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: 07/01/2015 Ending: 06/30/2016

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		$ 8,228,381	$ 194,866		$ 194,866	$	$ 1,876,584	1
2	rvs Arch Fees Already Cap	2004	(1,655)	(41)	40	(41)		(517)	2
3	Blue Prints IRC Laund Rvs	2008	(122)	(3)	40	(3)		(38)	3
4	Contract Serv IRC Laun Rvs	2010	(3,023)	(76)	40	(76)		(945)	4
5	Door Hold - Magnetic	2012	1,404	140	10	140		1,053	5
6	Remodel 8 Private Rooms	2008	44,255	2,950	15	2,950		19,177	6
7	Lighting for IRC	2008	10,519	1,052	10	1,052		4,733	7
8	IRC Boiler Tank	2008	3,373	337	10	337		2,867	8
9	Nurse Call System	2008	54,966	5,497	10	5,497		41,224	9
10	Air Conditioning/Cooling	2009	4,050		5			4,050	10
11	Boiler Replacement	2011	432,708	21,635	20	21,635		162,265	11
12	Magnetic Door Holder	2011	1,334	133	10	133		1,001	12
13	Air Conditioner Replace IRC	2011	5,265	351	15	351		1,580	13
14	Upgrade Entrances to Handicap	2012	10,023	1,002	10	1,002		4,510	14
15	Handicap Door Access	2012	2,867	287	10	287		1,290	15
16	Feed Wiring for New Sign	2012	1,250	63	20	63		281	16
17	IRC Patient Room Upgrades	2012	25,676	2,568	10	2,568		8,987	17
18	IRC Patient Room Upgrades	2013	11,106	740	15	740		2,591	18
19	IRC Patient Room Upgrades	2013	191,619	9,581	20	9,581		33,533	19
20	Renovation of Shelter/Medicare	2013	6,097	1,219	5	1,219		4,268	20
21	Renovation of Shelter/Medicare	2013	178,023	17,802	10	17,802		62,308	21
22	Renovation of Bath and Station	2006	2,139	214	10	214		749	22
23	Keypad Release Lock	2008	6,776	1,355	5	1,355		3,388	23
24	Electric Switch Gear	2008	3,719	248	15	248		2,355	24
25	IRC Boiler Replacement	2008	99,083	5,828	17	5,828		43,713	25
26	Replace Nurse Call System	2009	60,202	6,020	10	6,020		45,151	26
27	Fire Damper Doors LSC Survey	2009	7,877	394	20	394		2,954	27
28	Replace Fire Alarm Panel	2009	62,446	6,245	10	6,245		46,835	28
29	Replace Chiller Module IRC N	2010	14,723	1,472	10	1,472		9,570	29
30	Domestic Hot Water Pumps	2010	56,488	3,766	15	3,766		24,478	30
31	Sprinkler System Internal	2012	50,187	2,007	25	2,007		13,049	31
32	Emerg Power IRC Pt Rooms	2013	15,721	1,048	15	1,048		6,813	32
33	Add AC Units to Cool Offices	2015	13,450	1,345	10	1,345		6,053	33
34	TOTAL (lines 1 thru 33)		$ 9,600,926	$ 290,047		$ 290,047	$	$ 2,435,910	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: 07/01/2015 Ending: 06/30/2016

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		$ 9,600,926	$ 290,047		$ 290,047	$	$ 2,435,910	1
2	Replace Failed Boiler IRC N	1992	31,353	1,568	20	1,568		3,919	2
3	Replace Failing Boiler IRC	1992	31,118	1,556	20	1,556		2,334	3
4	Nurses Station	2010	457		10			457	4
5	Nurse Call System	2012	2,043		15			2,043	5
6	Remodel 8 Private Rooms	2003	7,888		5			7,888	6
7	Sink for Soiled Utility Room	2003	9,165	458	20	458		1,604	7
8	Air Conditioning Unit	1991	2,755		7			2,755	8
9	IRC Door Alarm	1991	5,792		10			5,792	9
10	1 Sign 3'X10' Single Side	1991	3,826		12			3,826	10
11	Fans	1991	2,017		15			2,017	11
12	Lockers,Toilet Accessorie	1991	5,747		15			5,747	12
13	Cabinets, Casework	1992	23,231		20			23,231	13
14	Elevators	1992	13,665		20			13,665	14
15	Signs	1992	503		12			503	15
16	Handrail And Door	1993	1,470		15			1,470	16
17	Door Access	1992	856		10			856	17
18	Crosstown Sign	1992	1,305		12			1,305	18
19	Alarm System	1992	587		15			587	19
20	Smoke Door Holders	1993	779		10			779	20
21	Cntrl Domestic Water Heat	1995	466		10			466	21
22	Wanderguard Depart Alert	1996	3,117		10			3,117	22
23	Drapes-Employee Lounge	1996	1,464		5			1,464	23
24	Major Repairs Irc Boiler	1997	9,872		5			9,872	24
25	Directory Board For Wall	1997	797		10			797	25
26	Remodel Irc Nurse Station	1998	3,340		15			3,340	26
27	Cabinets/Storage-Utli Rm	1994	4,103		15			4,103	27
28	Double Egress Wood Doors	1998	2,756		15			2,756	28
29	Window Coverings-Pt Area	1999	1,467		5			1,467	29
30	Lock Sets Mastered To Key	2000	2,642		5			2,642	30
31	Wood Replace Doors-Irc 4 Rooms	2001	1,308		15			1,308	31
32	4"" Sprinkler	2001	18,675	747	25	747		12,325	32
33	Air Cond/Handling Unit	2001	2,187		10			2,187	33
34	TOTAL (lines 1 thru 33)		$ 9,797,675	$ 294,376		$ 294,376	$	$ 2,562,531	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: 07/01/2015 Ending: 06/30/2016

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		$ 9,797,675	$ 294,376		$ 294,376	$	$ 2,562,531	1
2	Irc Boiler Stack	2002	14,750	738	20	738		11,431	2
3	Pa System Irc Dining Room	2002	1,682		10			1,682	3
4	Irc Bedpan Washers	2002	2,923	195	15	195		2,825	4
5	Switchboard Cable Irc	2003	4,831		10			4,831	5
6	Boiler Fail Over Controls	2012	1,905		10			1,905	6
7	Bronze Circulating Pump	2012	1,937		10			1,937	7
8	Therapy Equipment IRC	1996	2,167	144	15	144		506	8
9	IRC Patient Room Upgrades	2000	8,362	1,672	5	1,672		5,853	9
10	Carpet Apts 240 & 249	2000	1,440		5			1,440	10
11	Data Voice Wiring-SC	2000	31,453		10			31,453	11
12	Door Alarm-Sheltered Care	2001	2,211		10			2,211	12
13	Analog Message-Sheltered Care	2001	2,693		10			2,693	13
14	Nurse Call System-Sc	1991	6,498		10			6,498	14
15	Kitchen Cabinets-Sc	2006	4,077	136	15	136		4,077	15
16	Dining Room Sound System	1994	1,561		5			1,561	16
17	Drapes (Fabric & Sheer)	1995	2,304		5			2,304	17
18	Cs Carpet Apt #117	1996	690		5			690	18
19	Emerson Air Conditioner	1996	594		10			594	19
20	190 Gal Verticl Asme Tank	2001	2,650		10			2,650	20
21	Hot Water Tank - Labor	2003	1,749		10			1,749	21
22	Door Wooden Irc	2004	1,465	98	15	98		1,417	22
23	Canopy	2004	2,275	152	15	152		1,896	23
24	Air Handling IRC Laundry	1991	19,065	953	20	953		11,916	24
25	Rvs Air Handling Cap FY03	1991	(19,065)	(953)	20	(953)		(11,916)	25
26	Sod	1991	1,945		10			1,945	26
27	Parking Curbs	1995	577		10			577	27
28	Landscaping	1996	1,050		10			1,050	28
29	Concrete Curb&Walk,Aph Rd	1998	27,738		15			27,738	29
30	Landscaping	2001	9,100		10			9,100	30
31	Sidewalk	2002	710		15			710	31
32	Parking Lot 4 Repairs-Irc	2002	3,561		8			3,561	32
33	Landscaping-Irc	2012	2,176		10			2,176	33
34	TOTAL (lines 1 thru 33)		$ 9,944,746	$ 297,510		$ 297,510	$	$ 2,701,587	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: 07/01/2015 Ending: 06/30/2016

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		$ 9,944,746	$ 297,510		$ 297,510	$	$ 2,701,587	1
2	Concrete Replacement	2012	2,239	75	15	75		2,239	2
3	Asphalt Parking Lot-Nw Area	1993	44,394		8			44,394	3
4	Parking Lot Lights Nw Area	1994	9,535		10			9,535	4
5	New Freestanding Sign	2005	5,905	591	10	591		2,657	5
6	Replace Sidewalks	2008	15,535	1,036	15	1,036		3,625	6
7	New Seeding/Mulch	2008	5,131		10			5,131	7
8	Repair Sidewalk	2012	1,874		15			1,874	8
9	LANDSCAPING	2005	2,511	126	10	126		2,511	9
10	Repair Sidewalk LSC Survey	2008	2,257	150	15	150		1,279	10
11	Replace Asphalt Entry Drive	2008	23,800	1,587	15	1,587		11,900	11
12	Resurface IRC Parking Lot	2012	16,117	2,015	8	2,015		7,051	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)		$ 10,074,044	$ 303,088		$ 303,088	$	$ 2,793,784	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: 07/01/2015 Ending: 06/30/2016

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	$ 1,398,953	$ 68,775	$ 68,775	$		$ 1,155,829	71
72	Current Year Purchases	13,016	1,562	1,562			1,562	72
73	Fully Depreciated Assets	629,662					629,662	73
74								74
75	TOTALS	$ 2,041,630	$ 70,337	$ 70,337	$		$ 1,787,053	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)	$ 12,173,397	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 373,425	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 373,425	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)	$ 4,580,836	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: 07/01/2015 Ending: 06/30/2016

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: 07/01/2015 Ending: 06/30/2016

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 | STATE OF ILLINOIS # 0048264 | Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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				338,062		338,062	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			$		$	$ 338,062		$ 338,062	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:** 07/01/2015 **Ending:** 06/30/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/2016 **(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	$ 155,346	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,243,572		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)	54,618		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,453,536	$	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	14,183,186		14
15	Leasehold Improvements, at Historical Cost	411,960		15
16	Equipment, at Historical Cost	2,222,002		16
17	Accumulated Depreciation (book methods)	(10,706,204)		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	189,116		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,357,783	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,811,319	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 107,966	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,378,583		30
31	Accrued Taxes Payable (excluding real estate taxes)	45,164		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	160,150		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Affiliate & Third Party Payable	497,141		36
37	Other Accrued Expenses	213,740		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,402,745	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,991,597		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Other Accrued Pension Cost	85,901		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,077,498	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,480,243	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,331,076	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,811,319	$	48

***(See instructions.)**

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,686,721	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,686,721	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,177,350)	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**	1,128	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,176,222)	17
	B. Transfers (Itemize):		
18	**EQUITY TRANSFERS**	(2,841,575)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (2,841,575)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,331,076)	24 *

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

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	$ 13,123,305	1
2	Discounts and Allowances for all Levels	(3,685,915)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,437,390	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	45,907	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		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)**	$ 101,551	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	Outreach	(283)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (283)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,538,658	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,205,703	31
32	Health Care	4,513,098	32
33	General Administration	2,843,243	33
	B. Capital Expense		
34	Ownership	502,959	34
	C. Ancillary Expense		
35	Special Cost Centers	1,651,004	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)***	$ 10,716,009	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,177,350)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,177,350)	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: 07/01/2015 Ending: 06/30/2016

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	1,837	2,069	$ 85,036	$ 41.11	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	28,874	31,160	970,212	31.14	3
4	Licensed Practical Nurses	19,798	21,227	427,648	20.15	4
5	CNAs & Orderlies	85,590	90,259	1,259,933	13.96	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	13,306	14,436	490,227	33.96	7
8	Rehab/Therapy Aides	18,145	19,841	378,350	19.07	8
9	Activity Director	0	0	0		9
10	Activity Assistants	5,812	6,130	79,314	12.94	10
11	Social Service Workers	2,803	3,094	70,428	22.76	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	0	0	0		15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	1,073	1,075	15,256	14.19	17
18	Housekeepers	0	0	0		18
19	Laundry	0	0	0		19
20	Administrator	2,900	3,161	225,715	71.41	20
21	Assistant Administrator	0	0	2,975		21
22	Other Administrative	2,351	2,850	44,602	15.65	22
23	Office Manager	0	0	0		23
24	Clerical	3,546	4,195	76,518	18.24	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	0	0	0		31
32	Other Health Care(specify)	9,806	10,643	241,263	22.67	32
33	Other(specify)	0	0			33
34	TOTAL (lines 1 - 33)	195,842	210,139	$ 4,367,476 *	$ 20.78	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: 07/01/2015 Ending: 06/30/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Hutchison, Kelli K	Asst, Administrative		$ 5,788
Moore, Michael D	Administrator, Senior Service		95,520
Roebuck, Glenwood W	Dir, Executive		60,854
Schmidt, DeShawn	Administrator, Senior Service		38,027
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 200,189

B. Administrative - Other

Description	Amount
Corp Overhead Allocation	$ 1,442,463
Contracted Services	22,813
Subscriptions, Cert, Conf, Travel	28,640
Miscellaneous	18,028
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 1,511,944

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Financial	$ 160
Frost Ruttenberg and	Financial	185
Conceptual Designs In	Design	5,269
Wescom Solutions Inc	Software	24,005
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 29,619

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 17,446
Unemployment Compensation Insurance	11,075
FICA Taxes	309,649
Employee Health Insurance	375,974
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Pension	127,842
Life Insurance	4,652
Long Term Disability	14,132
Employee Assistance Program	10,486
Tuition Reimbursement	3,600
TOTAL (agree to Schedule V, line 22, col.8)	$ 874,854

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	
Transportation	154
Mileage	778
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 932

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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? **No**
If YES, give association name and amount.

(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. $ **11,678** 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. **No**

(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. $ **147,306**
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? **v** 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?
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) 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