FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0048264

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

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

County: Rock Island

Telephone Number: (309) 792-7614 **Fax #** (309) 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 07/01/2016 to 06/30/2017 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Mark G. Rogers

(Title) Vice President, Finance/CFO

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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	6,029	11,252	9,209	26,490	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		4,166		4,166	12
13	DD 16 OR LESS					13
14	TOTALS	6,029	15,418	9,209	30,656	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.99%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 26,490

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: 06/30/2017 Fiscal Year: 06/30/2017

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

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative C # 0048264 **Report Period Beginning:** 07/01/2016 **Ending:** 06/30/2017

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			483,667	483,667		483,667	(4,396)	479,271			1
2	Food Purchase		254,220		254,220		254,220	(21)	254,199			2
3	Housekeeping		52,609	163,916	216,525		216,525		216,525			3
4	Laundry							71,893	71,893			4
5	Heat and Other Utilities			49,527	49,527		49,527		49,527			5
6	Maintenance	10,361	57,013	110,272	177,646		177,646	13,504	191,150			6
7	Other (specify):*							140,737	140,737			7
8	**TOTAL General Services**	10,361	363,842	807,382	1,181,585		1,181,585	221,717	1,403,302			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	3,076,537	245,660	358,802	3,680,999		3,680,999	60,620	3,741,619			10
10a	Therapy	655,917	2,637	24,927	683,481		683,481	(55,644)	627,837			10a
11	Activities	56,567	5,145	10,263	71,975		71,975	150	72,125			11
12	Social Services	72,944		1,529	74,473		74,473		74,473			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,861,965	253,442	395,521	4,510,928		4,510,928	5,126	4,516,054			16
	C. General Administration											
17	Administrative	231,588	8,116	949,131	1,188,835		1,188,835	(350,316)	838,519			17
18	Directors Fees											18
19	Professional Services			26,662	26,662		26,662		26,662			19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses	192,150	13,618	19,390	225,158		225,158	2,638	227,796			21
22	Employee Benefits & Payroll Taxes			751,222	751,222		751,222	(441,535)	309,687			22
23	Inservice Training & Education											23
24	Travel and Seminar			831	831		831		831			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			(383)	(383)		(383)	383				26
27	Other (specify):*											27
28	**TOTAL General Administration**	423,738	21,734	1,746,853	2,192,325		2,192,325	(788,830)	1,403,495			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,296,064	639,018	2,949,756	7,884,838		7,884,838	(561,987)	7,322,851			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care #0048264 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			338,882	338,882		338,882	(84,694)	254,188			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			102,441	102,441		102,441	(103,148)	(707)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			441,323	441,323		441,323	(187,842)	253,481			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		419,657		419,657		419,657		419,657			39
40	Barber and Beauty Shops			13,117	13,117		13,117		13,117			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			193,220	193,220		193,220		193,220			42
43	Other (specify):*	134,489	204,381	1,513,329	1,852,199		1,852,199	51,730	1,903,929			43
44	**TOTAL Special Cost Centers**	134,489	624,038	1,719,666	2,478,193		2,478,193	51,730	2,529,923			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,430,553	1,263,056	5,110,745	10,804,354		10,804,354	(698,099)	10,106,255			45

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

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,396)	1		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	(707)	32		10
11	Discounts, Allowances, Rebates & Refunds	(29)	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	(3,206)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (63,982)		$	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))**	$ (63,982)		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

STATE OF ILLINOIS **Page 5A**

Illini Nursing Home d/b/a Illini Restorative Care

ID# **0048264**

Report Period Beginning: **07/01/2016**

Ending: **06/30/2017**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Distribution - Miscellaneous Revenue	$ (940)	17	1
2	Nursing Floor - IRC Medicare - Miscellaneous Revenue	(2,416)	10	2
3	Activity - IRC - Outreach Revenue	150	11	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**	(3,206)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care **#** 0048264 **Report Period Beginning:** 07/01/2016 **Ending:** 06/30/2017

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(4,396)	0	0	0	0	0	0	0	0	0	0	(4,396)	1
2	Food Purchase	0	(21)	0	0	0	0	0	0	0	0	0	(21)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	71,893	0	0	0	0	0	0	0	0	0	71,893	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	13,504	0	0	0	0	0	0	0	0	0	13,504	6
7	Other (specify):*	0	140,737	0	0	0	0	0	0	0	0	0	140,737	7
8	**TOTAL General Services**	(4,396)	226,113	0	0	0	0	0	0	0	0	0	221,717	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	(2,416)	63,036	0	0	0	0	0	0	0	0	0	60,620	10
10a	Therapy	(55,644)	0	0	0	0	0	0	0	0	0	0	(55,644)	10a
11	Activities	150	0	0	0	0	0	0	0	0	0	0	150	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**	(57,910)	63,036	0	0	0	0	0	0	0	0	0	5,126	16
	C. General Administration													
17	Administrative	(969)	(349,347)	0	0	0	0	0	0	0	0	0	(350,316)	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	2,638	0	0	0	0	0	0	0	0	0	2,638	21
22	Employee Benefits & Payroll Taxes	0	(441,535)	0	0	0	0	0	0	0	0	0	(441,535)	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	383	0	0	0	0	0	0	0	0	0	383	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(969)	(787,861)	0	0	0	0	0	0	0	0	0	(788,830)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(63,275)	(498,712)	0	0	0	0	0	0	0	0	0	(561,987)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Illini Nursing Home d/b/a Illini Restorative Care** **# 0048264** **Report Period Beginning: 07/01/2016 Ending: 06/30/2017**

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	(84,694)	0	0	0	0	0	0	0	0	0	(84,694)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(707)	(102,441)	0	0	0	0	0	0	0	0	0	(103,148)	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**	(707)	(187,135)	0	0	0	0	0	0	0	0	0	(187,842)	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	51,730	0	0	0	0	0	0	0	0	0	51,730	43
44	**TOTAL Special Cost Centers**	0	51,730	0	0	0	0	0	0	0	0	0	51,730	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(63,982)	(634,117)	0	0	0	0	0	0	0	0	0	(698,099)	45

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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	$ 21	GMC Silvis (B Pt I Allocated Cost)	100.00%	$	$ (21)	1
2	V	4	Laundry		GMC Silvis (B Pt I Allocated Cost)	100.00%	71,893	71,893	2
3	V	6	Plant OP/Maintenance		GMC Silvis (B Pt I Allocated Cost)	100.00%	13,504	13,504	3
4	V	7	Cafeteria		GMC Silvis (B Pt I Allocated Cost)	100.00%	140,737	140,737	4
5	V	10	Medical Records		GMC Silvis (B Pt I Allocated Cost)	100.00%	63,036	63,036	5
6	V	17	Administrative & General	1,842,421	GMC Silvis (B Pt I Allocated Cost)	100.00%	1,493,074	(349,347)	6
7	V	21	Clerical & General Office Expense	38,650	GMC Silvis (B Pt I Allocated Cost)	100.00%	41,288	2,638	7
8	V	22	Employee Benefits	702,704	GMC Silvis (B Pt I Allocated Cost)	100.00%	261,169	(441,535)	8
9	V	26	Insurance-Prop.Liab.Malpractice	(383)	GMC Silvis (B Pt I Allocated Cost)	100.00%		383	9
10	V	30	CRC Bldgs & Fixt-Depr	338,882	GMC Silvis (B Pt I Allocated Cost)	100.00%	254,188	(84,694)	10
11	V	32	CRC Bldgs & Fixt-Interst	102,441	GMC Silvis (B Pt I Allocated Cost)	100.00%		(102,441)	11
12	V	43	Crosstown Square	214,566	GMC Silvis (B Pt I Allocated Cost)	100.00%	266,296	51,730	12
13	V								13
14	Total			$ 3,239,302			$ 2,605,185	$ * (634,117)	14

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

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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 Nursing Home d/b/a Illini Restorative C # 0048264 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

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

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

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

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2016 Ending: 6/30/2017

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 Nursing Home d/b/a Illini Restorative C # 0048264 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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	6/28/06	$ 11,000,000	$	7/08/11	0.0690	$	1
2	GMC Silvis	X		Mortgage	$90,699.35	06/02/10	8,958,390	2,991,597	5/30/20	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	$ 2,991,597			$	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	$ 2,991,597			$	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 Nursing Home d/b/a Illini Restorative Care **#** 0048264 **Report Period Beginning:** 07/01/2016 **Ending:** 06/30/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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 2017 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:		
2012	N/A	8
2013	N/A	9
2014	N/A	10
2015	N/A	11
2016	N/A	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

FACILITY IDPH LICENSE NUMBER 0048264

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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 Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1991		$ 584,661	$ 14,617	40	$ 14,617	$	$ 383,684	4
5			2000		5,435,418	135,885	40	135,885		2,287,405	5
6											6
7											7
8											8
	Improvement Type**										
9	Plumbing,Sprinkler Work			1991	211,741		5			211,741	9
10	Heating			1991	157,820		5			157,820	10
11	Air Conditioning			1991	133,565		40			133,565	11
12	Electrical			1991	128,975		10			128,975	12
13	Legal & Professional			1991	89,731	2,243	10	2,243		58,886	13
14	Building			1991	88,055	2,201	40	2,201		57,786	14
15	Cabin,Toilets,Doors,Handr			1991	57,912		40			57,912	15
16	Wood Doors&Frames;Hardwar			1991	53,541		15			53,541	16
17	Plumbing&Electrical Util			1991	44,800		10			44,800	17
18	Co#23-Kitchen & Lounge			1991	40,623	1,016	15	1,016		26,659	18
19	Roof System,Asphalt Shing			1991	36,118		40			36,118	19
20	Paint & Wall Covering			1991	32,200		25			32,200	20
21	Est Nailers,Wood Trusses			1991	31,871		40			31,871	21
22	Concrete Curb&Walk,Aph Rd			1991	27,738		10			27,738	22
23	Co19,20,21,24,25,26,27,28			1991	27,371	684	20	684		17,962	23
24	Cabinets, Casework			1991	23,231		10			23,231	24
25	Acoustic Ceilings			1991	23,090		10			23,090	25
26	Co#1-7 Sewer Line&Overbed			1991	18,770		20			18,770	26
27	Carpet			1991	18,550		20			18,550	27
28	Time & Material Work			1991	17,753	444	10	444		11,650	28
29	Elevators			1991	13,665		40			13,665	29
30	Co#8-14(Exct9)Lights,Walk			1991	13,230		15			13,230	30
31	Metal Windows			1991	13,134		15			13,134	31
32	Resil Floor&Base,Stair Tr			1991	11,340		15			11,340	32
33	Landscaping			1991	9,100		10			9,100	33
34	Co29-Pipe Recepticals,Ect			1991	7,746		20			7,746	34
35	Alum Entrances&Storefront			1991	7,608		20			7,608	35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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	Lockers,Toilet Accessorie	1991	$ 5,747	$		$	$	$ 5,747	37
38	Co#33 - Copper Wire	1991	3,981					3,981	38
39	Co#18-Gutter & Downspouts	1991	3,929					3,929	39
40	Sheet Metal	1991	3,843					3,843	40
41	Ceramic Tile	1991	3,575					3,575	41
42	3 Wall Pack Lights	1991	3,472					3,472	42
43	Grade Insulation	1991	3,257					3,257	43
44	Co#16,17-Paint/Whirlpool	1991	2,590					2,590	44
45	Painting & Wallpaper	1991	2,032					2,032	45
46	Fans	1991	2,017					2,017	46
47	Carpet & Tile	1991	1,622					1,622	47
48	Co#32-Smoke Detect/Wiring	1991	1,605					1,605	48
49	Field Tests	1991	1,547	39		39		1,015	49
50	Co#15-Fire Exting&Cabinet	1991	1,106					1,106	50
51	Landscaping	1991	1,050					1,050	51
52	Co#9-Elevator Auto Ret Sy	1991	1,042					1,042	52
53	Kitchen Plan	1991	1,025	26		26		672	53
54	Electrical Supplies	1991	396					396	54
55	Co#30 - City Walk	1991	323					323	55
56	Co#31 - 2 Exit Light	1991	148					148	56
57	Sign Electrical Feed	1991	1,209					1,209	57
58	Parking Curbs	1991	577					577	58
59	Sod	1991	1,945					1,945	59
60	Dining Room Sound System	1991	1,561					1,561	60
61	1 Sign 3'X10' Single Side	1991	3,826					3,826	61
62	Signs	1992	503					503	62
63	Nurses Station	1992	457					457	63
64	Nurse Call System	1992	2,043					2,043	64
65	Handrail And Door	1992	1,470					1,470	65
66	Door Access	1992	856					856	66
67	Cntrl Domestic Water Heat	1992	466					466	67
68	Wallpaper & Carpeting	1992	3,326					3,326	68
69	Smoke Door Holders	1992	779					779	69
70	TOTAL (lines 4 thru 69)		$ 7,422,680	$ 157,155		$ 157,155	$	$ 3,982,217	70

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

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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		$ 7,422,680	$ 157,155		$ 157,155	$	$ 3,982,217	1
2	Chandelier	1992	492		10			492	2
3	Alarm System	1992	587		15			587	3
4	Vinyl	1992	578		5			578	4
5	Carpet	1992	438		20			438	5
6	Crosstown Sign	1993	1,305		12			1,305	6
7	New Seeding/Mulch	1993	5,131		10			5,131	7
8	Wanderguard Depart Alert	1993	3,117		10			3,117	8
9	Circuit Panel, A/C Outlet	1993	930		10			930	9
10	Repair Sidewalk	1994	1,874		10			1,874	10
11	Cs Carpet Apt #117	1994	690		5			690	11
12	Air Condition Installatio	1994	498		15			498	12
13	Handrails - Irc	1994	5,358		15			5,358	13
14	Window Coverings-Pt Area	1994	1,467		5			1,467	14
15	Sidewalk	1995	710		15			710	15
16	Tile & Base For Hallway	1995	2,183		10			2,183	16
17	Tile For Irc Hallway	1995	1,004		10			1,004	17
18	P.T. Utility Study	1995	142,758		10			142,758	18
19	Irc Hall Tile Repair	1995	694		15			694	19
20	Emerson Air Conditioner	1995	594		10			594	20
21	Drapes-Employee Lounge	1995	1,464		5			1,464	21
22	190 Gal Verticl Asme Tank	1996	2,650		10			2,650	22
23	Hot Water Tank - Labor	1996	1,749		10			1,749	23
24	Carpet Apts 240 & 249	1996	1,440		5			1,440	24
25	Directory Board For Wall	1996	797		10			797	25
26	Major Repairs Irc Boiler	1996	9,872		5			9,872	26
27	Parking Lot 4 Repairs-Irc	1996	3,561		8			3,561	27
28	Cabinets/Storage-Utli Rm	1997	4,103		15			4,103	28
29	Remodel Irc Nurse Station	1997	3,340		15			3,340	29
30	Air Compressor For Chillr	1997	14,196		15			14,196	30
31	Double Egress Wood Doors	1998	2,756		15			2,756	31
32	Lock Sets Mastered To Key	1998	2,642		5			2,642	32
33	Landscaping-Irc	1998	2,176		10			2,176	33
34	TOTAL (lines 1 thru 33)		$ 7,643,833	$ 157,155		$ 157,155	$	$ 4,203,369	34

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

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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		$ 7,643,833	$ 157,155		$ 157,155	$	$ 4,203,369	1
2	Carpet Lobby & Office Areas	1998	3,123					3,123	2
3	Tie-In Piping Hot Water To Irc	1998	1,766	88		88		1,633	3
4	VPI Base & Ceramic Tile	1999	1,385					1,385	4
5	Wood Replace Doors-Irc 4 Rooms	1999	1,308					1,308	5
6	4"" Sprinkler	2000	18,675	747		747		13,072	6
7	Data Voice Wiring-SC	2000	31,453					31,453	7
8	Analog Message-Sheltered Care	2000	2,693					2,693	8
9	Door Alarm-Sheltered Care	2000	2,211					2,211	9
10	Air Cond/Handling Unit	2001	2,187					2,187	10
11	Nurse Call System-Sc	2001	6,498					6,498	11
12	Kitchen Cabinets-Sc	2001	4,077					4,077	12
13	Irc Roof Hatches	2001	2,420					2,420	13
14	Irc Boiler Stack	2001	14,750	738		738		12,169	14
15	Carpentry Patient Room Showers	2001	9,326					9,326	15
16	Concrete Replacement	2001	2,239					2,239	16
17	Paint Wallpaper Carpet, Act	2001	1,926					1,926	17
18	Pa System Irc Dining Room	2001	1,682					1,682	18
19	Door And Door Closers Exam Rm	2001	1,524					1,524	19
20	Sheltered Care Addition	2001	(196,204)	(4,905)		(4,905)		(78,481)	20
21	Door Wooden Irc	2001	1,465	49		49		1,465	21
22	Irc Cooling Unit Controls	2002	4,567					4,567	22
23	Ahu Valve Control Upgrade	2002	3,328					3,328	23
24	Irc Wanderguard Relocation	2002	3,122					3,122	24
25	Irc Bedpan Washers	2002	2,923	97		97		2,923	25
26	Irc Wall Hydrants	2002	1,354					1,354	26
27	Medicare Rooms Wall Guards	2002	772					772	27
28	Switchboard Cable Irc	2002	4,831					4,831	28
29	Boiler Fail Over Controls	2002	1,905					1,905	29
30	Asphalt Parking Lot-Nw Area	2002	44,394					44,394	30
31	Irc Carpet Hallway	2002	10,072					10,072	31
32	Parking Lot Lights Nw Area	2002	9,535					9,535	32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,645,139	$ 153,969		$ 153,969	$	$ 4,314,082	34

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

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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		$ 7,645,139	$ 153,969		$ 153,969	$	$ 4,314,082	1
2	Double Egress Door Replacement	2002	4,342	217		217		3,365	2
3	Security System	2003	6,267					6,267	3
4	IRC Loading Dock	2003	97,613	3,905		3,905		56,616	4
5	IRC Door Alarm	2003	5,792					5,792	5
6	Air Conditioning Unit	2003	2,755					2,755	6
7	Canopy	2003	2,275	152		152		2,048	7
8	PT Construction	2004	93,098	2,327		2,327		31,421	8
9	PT Construction	2004	80,180	2,005		2,005		27,061	9
10	Architect Fees	2004	41,400	1,035		1,035		13,973	10
11	Wallcoverings	2004	490					490	11
12	Blue Prints PT	2004	36	1		1		12	12
13	Contact Services IRC Laundry	2004	60,362	1,509		1,509		20,372	13
14	Construction IRC Laundry	2004	24,446	611		611		8,250	14
15	Air Handling IRC Laundry	2004	19,065	953		953		12,869	15
16	Architect Fees IRC Laundry	2004	7,056	176		176		2,382	16
17	Blue Prints IRC Laundry	2004	122	3		3		41	17
18	Blue Prints IRC Laund Rvs	2004	(122)	(3)		(3)		(41)	18
19	rvs Arch Fees Already Cap	2004	(1,655)	(41)		(41)		(558)	19
20	Contract Serv IRC Laun Rvs	2004	(3,023)	(76)		(76)		(1,020)	20
21	Rvs Air Handling Cap FY03	2004	(19,065)	(953)		(953)		(12,869)	21
22	AIR/DIRT SEPARATOR	2004	4,905					4,905	22
23	BOILER REPLACEMENT DEAERATOR	2005	24,668	1,774		1,774		20,232	23
24	Roof	2005	51,860					51,860	24
25	Acuator Controls	2005	4,092	205		205		2,353	25
26	LANDSCAPING	2005	2,511					2,511	26
27	CONSTRUCTION	2005	199,131					199,131	27
28	CONDUIT & WIRING	2005	1,539	77		77		885	28
29	DESIGN FEES	2005	15,555					15,555	29
30	Valve Replacements	2006	12,432	622		622		7,149	30
31	DESIGN FEES	2006	1,601					1,601	31
32	HOLLOW METAL DOORS	2006	10,987	549		549		6,317	32
33	Drapes (Fabric & Sheer)	2006	2,304					2,304	33
34	TOTAL (lines 1 thru 33)		$ 8,398,158	$ 169,016		$ 169,016	$	$ 4,808,109	34

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

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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		$ 8,398,158	$ 169,016		$ 169,016	$	$ 4,808,109	1
2	Electric Switch Gear	2006	3,719	248	15	248		2,603	2
3	IRC Boiler Tank	2008	3,373	337	10	337		3,204	3
4	Repair Sidewalk LSC Survey	2008	2,257	150	15	150		1,429	4
5	Boiler Replacement	2008	432,708	21,635	10	21,635		183,901	5
6	IRC Boiler Replacement	2008	99,083	5,828	10	5,828		49,541	6
7	Replace Nurse Call System	2008	60,202	6,020	5	6,020		51,172	7
8	Nurse Call System	2008	54,966	5,497	20	5,497		46,721	8
9	Fire Damper Doors LSC Survey	2008	7,877	394	17	394		3,348	9
10	Air Conditioning/Cooling	2008	4,050		10			4,050	10
11	Door Hold - Magnetic	2008	1,404	140	20	140		1,193	11
12	Replace Asphalt Entry Drive	2008	23,800	1,587	15	1,587		13,487	12
13	Replace Corridor Doors	2009	15,509	1,034	15	1,034		8,788	13
14	Magnetic Door Holder	2009	1,334	133	10	133		1,134	14
15	Replace Fire Alarm Panel	2009	62,446	6,245	10	6,245		53,079	15
16	Domestic Hot Water Pumps	2009	56,488	3,766	15	3,766		28,244	16
17	Replace Chiller Module IRC N	2009	14,723	1,472	10	1,472		11,042	17
18	Sprinkler System Internal	2010	50,187	2,007	25	2,007		15,056	18
19	Remodel 8 Private Rooms	2010	44,255	2,950	15	2,950		22,128	19
20	Remodel 8 Private Rooms	2010	7,888		5			7,888	20
21	Emerg Power IRC Pt Rooms	2010	15,721	1,048	15	1,048		7,861	21
22	Replace Old Roof Section - IRC	2011	122,994	12,299	10	12,299		67,647	22
23	Storm Sewer Repair	2011	4,434	177	25	177		976	23
24	Air Conditioner Replace IRC	2011	5,265	351	15	351		1,931	24
25	Upgrade Entrances to Handicap	2011	10,023	1,002	10	1,002		5,513	25
26	Handicap Door Access	2011	2,867	287	10	287		1,577	26
27	Lighting for IRC	2012	10,519	1,052	10	1,052		5,785	27
28	Add AC Units to Cool Offices	2012	13,450	1,345	10	1,345		7,398	28
29	New Freestanding Sign	2012	5,905	591	20	591		3,248	29
30	Feed Wiring for New Sign	2012	1,250	63	10	63		344	30
31	IRC Patient Room Upgrades	2012	191,619	9,581	10	9,581		43,114	31
32	IRC Patient Room Upgrades	2012	25,676	2,568	15	2,568		11,554	32
33	IRC Patient Room Upgrades	2012	11,106	740	20	740		3,332	33
34	TOTAL (lines 1 thru 33)		$ 9,765,255	$ 259,565		$ 259,565	$	$ 5,476,394	34

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

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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		$ 9,765,255	$ 259,565		$ 259,565	$	$ 5,476,394	1
2	Sink for Soiled Utility Room	2012	9,165	458	20	458		2,062	2
3	IRC Patient Room Upgrades	2012	8,362	1,672	5	1,672		7,526	3
4	Resurface IRC Parking Lot	2012	16,117	2,015	8	2,015		9,066	4
5	Replace Sidewalks	2012	15,535	1,036	15	1,036		4,661	5
6	Therapy Equipment IRC	2012	2,167	144	15	144		650	6
7	Renovation of Shelter/Medicare	2013	178,023	17,802	5	17,802		80,110	7
8	Renovation of Shelter/Medicare	2013	6,097	1,219	10	1,219		5,487	8
9	Renovation of Bath and Station	2013	2,139	214	10	214		963	9
10	Replace Failed Boiler IRC N	2013	31,353	1,568	20	1,568		5,487	10
11	Keypad Release Lock	2013	6,776	1,355	5	1,355		4,743	11
12	Replace Failing Boiler IRC	2015	31,118	1,556	20	1,556		3,890	12
13	IRC Nurse Call Upgrade ARMS IP	2016	23,632		10			1,182	13
14	IRC Domestic Hot Water Ext	2016	17,272		25			345	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)		$ 10,113,011	$ 288,604		$ 288,604	$	$ 5,602,566	34

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

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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	$ 422,418	$ 50,011	$ 50,011	$		$ 218,118	71
72	Current Year Purchases	32,233					1,612	72
73	Fully Depreciated Assets	988,809	267	267			988,809	73
74								74
75	TOTALS	$ 1,443,460	$ 50,277	$ 50,277	$		$ 1,208,538	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)	$ 11,589,912	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 338,882	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 338,882	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)	$ 6,811,104	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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.	/2018	$
13.	/2019	$
14.	/2020	$

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 Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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				419,657		419,657	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			$		$	$ 419,657		$ 419,657	14

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

STATE OF ILLINOIS

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care **#** 0048264 **Report Period Beginning:** 07/01/2016 **Ending:** 06/30/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/2017 **(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	$ 204,262	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,332,551		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,372		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	159,786		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,737,970	$	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	14,315,369		14
15	Leasehold Improvements, at Historical Cost	411,960		15
16	Equipment, at Historical Cost	2,252,244		16
17	Accumulated Depreciation (book methods)	(11,156,785)		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	214,074		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,094,585	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,832,556	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 40,240	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,416,743		30
31	Accrued Taxes Payable (excluding real estate taxes)	48,786		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	158,520		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Affiliate & Third Party Payable	697,168		36
37	Other Accrued Expenses	111,179		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,472,636	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,004,910		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,004,910	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,477,546	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,355,010	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,832,556	$	48

***(See instructions.)**

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care **#** 0048264 **Report Period Beginning:** 07/01/2016 **Ending:** 06/30/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,331,076	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,331,076	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,794,802)	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**	930	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,793,872)	17
	B. Transfers (Itemize):		
18	**Equity Transfers**	(3,892,214)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (3,892,214)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,355,010)	24 *

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

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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	$ 12,958,465	1
2	Discounts and Allowances for all Levels	(4,074,922)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,883,543	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	45,412	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	80,769	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	29	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)**	$ 126,210	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	(200)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (200)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,009,553	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,181,585	31
32	Health Care	4,510,927	32
33	General Administration	2,192,325	33
	B. Capital Expense		
34	Ownership	441,323	34
	C. Ancillary Expense		
35	Special Cost Centers	2,478,194	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)***	$ 10,804,355	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,794,802)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,794,802)	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 Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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	2,116	2,286	$ 99,906	$ 43.70	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	29,207	31,093	1,035,488	33.30	3
4	Licensed Practical Nurses	18,672	19,884	420,789	21.16	4
5	CNAs & Orderlies	83,615	88,525	1,257,815	14.21	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	12,228	13,092	451,734	34.50	7
8	Rehab/Therapy Aides	17,149	18,756	356,733	19.02	8
9	Activity Director	0	0	0		9
10	Activity Assistants	5,510	5,806	78,314	13.49	10
11	Social Service Workers	2,967	3,274	71,901	21.96	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	1,045	1,045	15,216	14.56	17
18	Housekeepers	0	0	0		18
19	Laundry	0	0	0		19
20	Administrator	2,764	3,061	228,725	74.72	20
21	Assistant Administrator	2,776	3,202	72,050	22.50	21
22	Other Administrative	0	0	0		22
23	Office Manager	0	0	0		23
24	Clerical	3,678	4,169	77,404	18.57	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)	10,508	11,531	264,477	22.94	32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	192,235	205,724	$ 4,430,553 *	$ 21.54	34

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

** See instructions.

B. CONSULTANT SERVICES

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

C. CONTRACT NURSES

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

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dykema, Jodi L	Administrator, Senior Service		$ 97,023
Hutchison, Kelli K	Asst. Administrative		7,800
Manthey, Sarah J	Manager		7,923
Roebuck, Glenwood W	Dir, Executive		72,398
Scherschel, Renae C	Coord, MDS		4,468
Schmidt, DeShawn	Administrator, Senior Service		41,976
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 231,588

B. Administrative - Other

Description	Amount
Corporate Allocation	$ 856,970
Dues	210
Other Administrative	91,951
TOTAL (agree to Schedule V, line 17, col. 3)	$ 949,131
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Point Click Care	Software	$ 26,247
Conceptual Designs In	Design	103
Marcum LLP	Financial	72
Snfdata Resources LLC	Financial	240
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 26,662

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 25,143
Unemployment Compensation Insurance	
FICA Taxes	312,142
Employee Health Insurance	409,935
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	(31,936)
Life Insurance	7,920
Long Term Disability	14,345
Employee Assistance	5,730
Wellness Program	246
Tuition Reimbursement	1,800
Other	5,898
TOTAL (agree to Schedule V, line 22, col.8)	$ 751,222

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	831
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 831

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Illini Nursing Home d/b/a Illini Restorative Care **#** 0048264 **Report Period Beginning:** 07/01/2016 **Ending:** 06/30/2017

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 politica
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. $ **14,740** 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 fo
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 Departmen
during this cost report period. $ **193,220**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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 fo
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