



Facility Name & ID Number Illini Hospital Nursing Home

# 0037143 Report Period Beginning: 7/1/03 Ending: 6/30/04

**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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	67	Skilled (SNF)	67	24,522	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	53	Sheltered Care (SC)	53	19,398	5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,920	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	4 Other		
8	SNF		531	6,724	7,255	8
9	SNF/PED					9
10	ICF	5,452	9,754		15,206	10
11	ICF/DD					11
12	SC		17,303		17,303	12
13	DD 16 OR LESS					13
14	TOTALS	5,452	27,588	6,724	39,764	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.54%

D. How many bed-hold days during this year were paid by Public Aid? 0 (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

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

I. On what date did you start providing long term care at this location?  
Date started 8/12/91

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 8/12/91 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 22 and days of care provided 7,255

Medicare Intermediary Cahaba GBA

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 6/30 Fiscal Year: 6/30

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

STATE OF ILLINOIS

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 Report Period Beginning: 7/1/03 Ending: 6/30/04

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary										1
2	Food Purchase		636,684		636,684		636,684	270,758	907,442		2
3	Housekeeping		11,763	228,608	240,371		240,371	(89,237)	151,134		3
4	Laundry							166,602	166,602		4
5	Heat and Other Utilities			113,886	113,886		113,886		113,886		5
6	Maintenance		5,897	162,067	167,964		167,964	19,259	187,223		6
7	Other (specify):* Cafeteria							138,329	138,329		7
8	<b>TOTAL General Services</b>		654,344	504,561	1,158,905		1,158,905	505,711	1,664,616		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			26,921	26,921		26,921		26,921		9
10	Nursing and Medical Records	1,758,414	16,576	64,494	1,839,484		1,839,484	127,070	1,966,554		10
10a	Therapy	(2,020)	13	250,870	248,863		248,863		248,863		10a
11	Activities	66,221	7,082	8,704	82,007		82,007	94,222	176,229		11
12	Social Services	62,941	6	2,098	65,045		65,045	94,477	159,522		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):* Central Svc/Supply										15
16	<b>TOTAL Health Care and Programs</b>	1,885,556	23,677	353,087	2,262,320		2,262,320	315,769	2,578,089		16
	<b>C. General Administration</b>										
17	Administrative	98,599	2,768	5,010	106,377		106,377	831,962	938,339		17
18	Directors Fees										18
19	Professional Services			79,000	79,000		79,000		79,000		19
20	Dues, Fees, Subscriptions & Promotions			6,543	6,543		6,543		6,543		20
21	Clerical & General Office Expenses	172,532	6,761	455,337	634,630		634,630	(252,251)	382,379		21
22	Employee Benefits & Payroll Taxes			341,883	341,883		341,883	168,688	510,571		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,629	6,629		6,629		6,629		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			157,221	157,221		157,221		157,221		26
27	Other (specify):* Other Acctg/Audit			499,238	499,238		499,238		499,238		27
28	<b>TOTAL General Administration</b>	271,131	9,529	1,550,861	1,831,521		1,831,521	748,399	2,579,920		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,156,687	687,550	2,408,509	5,252,746		5,252,746	1,569,879	6,822,625		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number

Illini Hospital Nursing Home

#0037143

Report Period Beginning:

7/1/03

Ending:

6/30/04

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			278,212	278,212		278,212	(238,502)	39,710			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			573,066	573,066		573,066	(6,324)	566,742			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			22,227	22,227		22,227		22,227			35
36	Other (specify):*			6,108	6,108		6,108		6,108			36
37	<b>TOTAL Ownership</b>			879,613	879,613		879,613	(244,826)	634,787			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		283,872		283,872		283,872		283,872			39
40	Barber and Beauty Shops			19,745	19,745		19,745	(21,130)	(1,385)			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		283,872	19,745	303,617		303,617	(21,130)	282,487			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,156,687	971,422	3,307,867	6,435,976		6,435,976	1,303,923	7,739,899			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Illini Hospital Nursing Home

# 0037143

Report Period Beginning: 7/1/03

Ending: 6/30/04

**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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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				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	(6,324)	32		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	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(24,646)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (30,970)		\$	30

OHF 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	2	
		Amount	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)	1,573,395		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 1,573,395		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 1,542,425		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	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Illini Hospital Nursing Home

ID# 0037143  
 Report Period Beginning: 7/1/03  
 Ending: 6/30/04

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Misc Income (acct 74.80010 4023 & 4300)	\$ (16)	21	1
2	Misc Income (acct 74.85510 4023)	(755)	3	2
3	Misc Income (acct 74.80710 4023)	(21,130)	40	3
4	Misc Income (acct 74.85010 4023)	(2,709)	2	4
5	Misc Income (acct 74.85030 4023)	(36)	2	5
6				6
7	Interest Income (acct 74.96000 98000 & 98100)			7
8	are offSet on PG5			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	<b>Total</b>	(24,646)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Illini Hospital Nursing Home

# 0037143

Report Period Beginning:

7/1/03

Ending:

6/30/04

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,745)	273,503	0	0	0	0	0	0	0	0	0	270,758	2
3	Housekeeping	(755)	(88,482)	0	0	0	0	0	0	0	0	0	(89,237)	3
4	Laundry	0	166,602	0	0	0	0	0	0	0	0	0	166,602	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	19,259	0	0	0	0	0	0	0	0	0	19,259	6
7	Other (specify):*	0	138,329	0	0	0	0	0	0	0	0	0	138,329	7
8	<b>TOTAL General Services</b>	<b>(3,500)</b>	<b>509,211</b>	<b>0</b>	<b>505,711</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	127,070	0	0	0	0	0	0	0	0	0	127,070	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	94,222	0	0	0	0	0	0	0	0	0	94,222	11
12	Social Services	0	94,477	0	0	0	0	0	0	0	0	0	94,477	12
13	Nurse Aide 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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>315,769</b>	<b>0</b>	<b>315,769</b>	<b>16</b>								
	<b>C. General Administration</b>													
17	Administrative	0	831,962	0	0	0	0	0	0	0	0	0	831,962	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	(16)	(252,235)	0	0	0	0	0	0	0	0	0	(252,251)	21
22	Employee Benefits & Payroll Taxes	0	168,688	0	0	0	0	0	0	0	0	0	168,688	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(16)</b>	<b>748,415</b>	<b>0</b>	<b>748,399</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(3,516)</b>	<b>1,573,395</b>	<b>0</b>	<b>1,569,879</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Illini Hospital Nursing Home# 0037143 Report Period Beginning:

7/1/03 Ending:

6/30/04

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

	Capital Expense	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)
	<b>D. Ownership</b>												
30	Depreciation	0	(238,502)	0	0	0	0	0	0	0	0	0	(238,502) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(6,324)	0	0	0	0	0	0	0	0	0	0	(6,324) 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	<b>TOTAL Ownership</b>	<b>(6,324)</b>	<b>(238,502)</b>	<b>0</b>	<b>(244,826) 37</b>								
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
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	(21,130)	0	0	0	0	0	0	0	0	0	0	(21,130) 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</b>	<b>(21,130)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(21,130) 44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(30,970)</b>	<b>1,334,893</b>	<b>0</b>	<b>1,303,923 45</b>								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Illini Nursing Home	100%	Illini Restorative Care Center	Silvis	Illini Hospital	Silvis, IL	Hospital
				Crosstown Square	Silvis, IL	Hospital
				Genesis Health System	Davenport, IA	Senior Apts.
						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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	22 Employee Benefits	\$ 345,155	Illini Hospital (B, Pt I allocated cost)	100.00%	\$ 513,843	\$ 168,688 1
2	V	17 Admin & General		Illini Hospital (B, Pt I allocated cost)	100.00%	803,564	803,564 2
3	V	4 Laundry & Linen		Illini Hospital (B, Pt I allocated cost)	100.00%	166,602	166,602 3
4	V	3 Housekeeping	240,370	Illini Hospital (B, Pt I allocated cost)	100.00%	151,888	(88,482) 4
5	V	2 Dietary	637,720	Illini Hospital (B, Pt I allocated cost)	100.00%	911,223	273,503 5
6	V	7 Cafeteria		Illini Hospital (B, Pt I allocated cost)	100.00%	138,329	138,329 6
7	V	17 Central Svc & Supply	536	Illini Hospital (B, Pt I allocated cost)	100.00%	28,934	28,398 7
8	V	30 CRC-Bldg&Fixtures	857,386	Illini Hospital (B, Pt I allocated cost)	100.00%	618,884	(238,502) 8
9	V	21 IRC Admin & General	1,365,329	Illini Hospital (B, Pt I allocated cost)	100.00%	1,113,094	(252,235) 9
10	V	6 Plant Operation	237,039	Illini Hospital (B, Pt I allocated cost)	100.00%	256,298	19,259 10
11	V	10 Nursing Admin	127,035	Illini Hospital (B, Pt I allocated cost)	100.00%	254,105	127,070 11
12	V	12 Social Service	65,210	Illini Hospital (B, Pt I allocated cost)	100.00%	159,687	94,477 12
13	V	11 Activity	82,702	Illini Hospital (B, Pt I allocated cost)	100.00%	176,924	94,222 13
14	Total		\$ 3,958,482			\$ 5,293,375	\$ * 1,334,893 14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 Report Period Beginning: 7/1/03 Ending: 6/30/04

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$	1	
2										2	
3										3	
4										4	
5										5	
6										6	
7										7	
8										8	
9										9	
10										10	
11										11	
12										12	
13									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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 Report Period Beginning: 7/1/03 Ending: 6/30/04

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

Name of Related Organization Illini Hospital  
 Street Address 801 Hospital Road  
 City / State / Zip Code Silvis, IL 61282  
 Phone Number (309) 792-4268  
 Fax Number (309) 792-4274

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/(col.4)x col.6)	
1	22	Employee Benefits	Gross Salaries	3	\$ 6,448,611	\$ 266,975	1,700,748	\$ 513,843	1
2	17	Admin & General	Accum Cost	3	11,412,050	1,691,241	3,340,167	803,564	2
3	4	Laundry & Linen	Laundry Pounds	3	650,528	76,517	213,873	166,602	3
4	3	Housekeeping	Square Feet	3	1,220,595	624,275	19,111	151,888	4
5	2	Dietary	Meals Served	3	2,927,100	531,032	124,973	911,223	5
6	7	Cafeteria	FTE's	3	1,004,713		6,067	138,329	6
7	15	Central Svc & Supply	Costed Requis.	3	1,596,521	265,424	109,571	28,934	7
8	30	CRC-Bldg&Fixtures	Square Feet	3	846,341		37,687	618,884	8
9	17	IRC Admin & General	Accum Cost	3	1,909,254	267,858	2,207,440	1,113,094	9
10	6	Plant Operation	Square Feet	3	323,501		19,111	256,298	10
11	10	Nursing Admin	Nursing Hours	3	254,105	59,533	6,425	254,105	11
12	12	Social Service	IRC Discharges	3	159,687	62,941	450	159,687	12
13	11	Activity	Patient Days	3	176,924	66,221	22,461	176,924	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				\$ 28,929,930	\$ 3,912,017		\$ 5,293,375	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 Report Period Beginning: 7/1/03 Ending: 6/30/04

**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		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
	<b>A. Directly Facility Related</b>																		
	<b>Long-Term</b>																		
1	Pacific Commonwealth		x			4/99	\$ 8,816,721	\$ 8,625,472	11/1/40	6.5000	\$ 562,673	1							
2												2							
3												3							
4												4							
5												5							
	<b>Working Capital</b>																		
6												6							
7												7							
8												8							
9	<b>TOTAL Facility Related</b>						\$ 8,816,721	\$ 8,625,472			\$ 562,673	9							
	<b>B. Non-Facility Related*</b>																		
10												10							
11												11							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14							
15	<b>TOTALS (line 9+line14)</b>						\$ 8,816,721	\$ 8,625,472			\$ 562,673	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 43,840 Line # 26

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

\*\* 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 Hospital Nursing Home**# **0037143** Report Period Beginning: **7/1/03** Ending: **6/30/04****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2003 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 2004 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	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:		1999	_____	8	
		2000	_____	9	
		2001	_____	10	
		2002	_____	11	
		2003	_____	12	
<b>FOR OHF USE ONLY</b>					
13	FROM R. E. TAX STATEMENT FOR 2003		\$		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.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2003 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Illini Hospital Nursing Home COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0037143

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 2003 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 2003.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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 & 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 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 57,055 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 1

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, nurse aide 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	220,902	1991, 1999	\$ 57,723	1
2					2
3	TOTALS	220,902		\$ 57,723	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Illini Hospital Nursing Home

# 0037143

Report Period Beginning:

7/1/03

Ending:

6/30/04

**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	120		2004	\$ 11,159,141	\$ 367,310	40	\$ 367,310	\$	\$ 3,779,669
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Land Improvement - 10 year #1, #2, #102, #189	1991		12,671		10			12,671
10	Land Improvement - 15 #187	1991		22,738	1,516	15	1,516		19,706
11	Carpet #239	1992		438		5			438
12	Vinyl Floorings # 240	1992		578	29	20	29		317
13	Chandelier # 241	1992		492		10			492
14	Wallpaper #244	1992		2,326		5			3,326
15	Signage #243	1993		1,305	109	12	109		1,087
16	Alarm System #247	1992		587	39	15	39		431
17	Smoke Door Hood #249	1992		779		10			779
18	Central Dumpster #250	1992		465		10			465
19	New Seeding/Mulch #261, #262	1993		10,415		10			12,415
20	Repair Sidewalk #274	1994		1,874	125	15	125		1,124
21	Circuit Panel A/C Outlet #265	1993		930		10			930
22	Install A/C #275	1994		498	50	10	50		448
23	FY95 Additions #278, #292, #294	1995		5,072	338	15	338		3,775
24	PT Therapy Utility Construction #305	1996		122,757	8,184	15	8,184		61,862
25	Canvas Awning #306 & Decorative Lighting #307	1996		20,660	1,377	15	1,377		13,844
26	Emerson #308	1996		594	59	10	59		417
27	Parking Lot Repair #317	1997		3,561		10			3,561
28	Major Repair IRC Boiler #319	1997		6,872	982	7	982		8,462
29	Directory Board #327	1997		797		5			797
30	Remodel IRC Nurse Station #330	1997		3,340	223	15	223		1,333
31	Cabinets-Stroage-Utility Room #331	1997		4,103	274	15	274		1,637
32	Carpet #329	1997		1,440		5			1,440
33	Hot Water Tank #328	1997		1,749		5			1,749
34	Tank #312	1996		2,650	265	10	265		1,855
35	Air compressor for Chiller #335	1997		11,196	746	15	746		5,682
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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Illini Hospital Nursing Home# 0037143

Report Period Beginning:

7/1/03

Ending:

6/30/04

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Double Egress Doors #341	1998	\$ 2,756	\$ 184	15	\$ 184	\$	\$ 1,102	37
38	Landscaping #352	1999	2,176	218	10	218		1,088	38
39	Carpet Lobby & Office Areas #361	1999	2,123	425	5	425		2,123	39
40	Tie-In Peping Hot Water to IRC #372	1999	1,766	88	20	88		442	40
41	Install VPI Bse & Ceramic Tile #376	1999	1,385	139	10	139		693	41
42	Lock Sets mastered to Key #349	1999	2,642	528	5	528		2,642	42
43	Wook Replacement Doors #388	2000	1,308	65	20	65		262	43
44	4" Sprinkler System #397	2000	12,675	507	25	507		2,028	44
45	Concrete Replacement #444	2001	2,239	112	20	112		336	45
46	IRC Roof Hatches #435	2001	2,420	242	10	242		726	46
47	Door and Door Closers Exam Room #440	2001	1,524	76	20	76		229	47
48	Activities Office-Paint, Wallpaper, Carpet #442	2001	1,926	385	5	385		1,156	48
49	Carpentry Patient Room Showers #443	2001	6,326	316	20	316		949	49
50	Air cond/Handling Unit3-Way Control Val #433	2001	2,187	219	10	219		656	50
51	IRC Boiler Stack #438	2001	11,750	588	20	588		1,763	51
52	PA Svstme IRC Dining Room #439	2001	1,682	168	10	168		505	52
53	Date Voice Wiring-SC #412	2001	21,453	2,145	10	2,145		6,436	53
54	Door Alarm - SC #413	2001	2,211	221	10	221		663	54
55	Analog Messge -SC #414	2001	2,693	269	10	269		808	55
56	Phone System-SC	2001	19,440	1,944	10	1,944		5,832	56
57	Nurse Call System - SC #436	2001	6,498	650	10	650		1,949	57
58	Kitchen Cabinets-SC #437	2001	4,077	272	15	272		815	58
59	Refrigerator, Washer, Dryer-SC #422,#423,#424	2001	1,665	111	15	111		333	59
60	Phones-SC #423,#427,#428	2001	4,224	845	5	845		2,534	60
61	Bearuty Shop-SC #425	2001	1,621	162	10	162		486	61
62	Parking Lot-NW Area-Asphalt & Lights #462, #463	2002	43,929	4,393	10	4,393		8,786	62
63	IRC Bldg Improv #451,#453,#454,#455,#456,#510	2002	17,485	1,749	10	1,749		3,497	63
64	IRC Hallway Carpet #464	2002	10,072	2,014	5	2,014		4,029	64
65	IRC Wooken Door #455, Bedban Washers #450	2002	4,388	219	20	219		439	65
66	IRC Switchboard cable #458, Boiler Fail over #461	2002	6,736	449	15	449		898	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 11,603,405	\$ 379,076		\$ 379,076	\$	\$ 3,948,309	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

STATE OF ILLINOIS

Facility Name & ID Number Illini Hospital Nursing Home

# 0037143

Report Period Beginning:

7/1/03

Ending:

Page 12B  
6/30/04

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 11,603,405	\$ 379,076		\$ 379,076	\$	\$ 3,948,309	1
2	Security System #513	2003	5,267	351	15	351		351	2
3	IRC Loading #626	2003	87,613	4,381	20	4,381		4,381	3
4	Parking Garage #518	2003	10,364	518	20	518		518	4
5	Bronze Cir #512	2003	1,937	194	10	194		194	5
6	Air Condit #516	2003	2,755	276	10	276		276	6
7	IRC Door Alarm #517	2003	4,792	479	10	479		479	7
8	Variance due to transfer via JE	2004	490						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	TOTAL (lines 1 thru 33)		\$ 11,716,623	\$ 385,274		\$ 385,274	\$	\$ 3,954,508	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 1,517,830	\$ 74,587	\$ 74,587	\$		\$ 1,059,540	71
72	Current Year Purchases	33,840						72
73	Fully Depreciated Assets							73
74	Variance due to transfer via JE	(490)						74
75	TOTALS	\$ 1,551,180	\$ 74,587	\$ 74,587	\$		\$ 1,059,540	75

D. Vehicle Depreciation (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	2	
	Reference	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)	\$ 13,325,526	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 459,861	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 459,861	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)	\$ 5,014,048	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.

**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:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

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.	<u>      /2005      </u>	\$ _____
13.	<u>      /2006      </u>	\$ _____
14.	<u>      /2007      </u>	\$ _____

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: \_\_\_\_\_ \*

**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: \$ 22,227 Description: PT, Nursing Admin, Nursing Floor, Maintenance Rental  
 (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	<b>TOTAL</b>		\$	\$	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.

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (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 aide 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 aides.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost	Units	Cost				
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	10a, 1-3	hrs	\$		\$		\$				\$		1
2	Licensed Speech and Language Development Therapist	10a, 1-3	hrs				8,685						8,685	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	10a, 1-3	hrs	(2,020)			242,152		1				240,133	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 prescripts						152,967				152,967	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify): <b>Chg Med Supplies</b>	39							130,905				130,905	13
14	<b>TOTAL</b>			\$ (2,020)		\$ 250,837		\$ 283,873			\$ 532,690			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 nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Illini Hospital Nursing Home**

# **0037143**

Report Period Beginning: **7/1/03**

Ending:

**6/30/04**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **6/30/04**

(last day of reporting year)

**This report must be completed even if financial statements are attached.**

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 713,073	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	621,577		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	789,862		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	24,639		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,149,151	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	312,815		13
14	Buildings, at Historical Cost	11,461,488		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,551,180		16
17	Accumulated Depreciation (book methods)	(5,014,049)		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 (spe <u>Unamort Bond Issue C</u> )	415,505		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 8,726,939	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 10,876,090	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 579,610	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	327		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	218,124		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Third Party Settlements</u>	153,909		36
37	<u>Other Accrued Expense</u>	78,895		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,030,865	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	11,732,778		41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 11,732,778	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 12,763,643	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,887,553)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 10,876,090	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(1,957,000)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(1,957,000)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	69,447	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>69,447</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(1,887,553)</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Illini Hospital Nursing Home

# 0037143

Report Period Beginning: 7/1/03

Ending:

6/30/04

**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.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 8,777,731	1
2	Discounts and Allowances for all Levels	(2,325,177)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,452,554	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients	1,281,504	5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,281,504	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		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	125,208	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 125,208	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	11,045	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 11,045	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,870,311	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services		31
32	Health Care	6,547,613	32
33	General Administration		33
<b>B. Capital Expense</b>			
34	Ownership	1,253,251	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,800,864	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	69,447	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 69,447	43

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

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

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

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

Facility Name & ID Number Illini Hospital Nursing Home

# 0037143

Report Period Beginning: 7/1/03

Ending:

6/30/04

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	3,598	4,085	\$ 93,162	\$ 22.81	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,561	10,436	224,644	21.53	3
4	Licensed Practical Nurses	30,120	33,110	525,780	15.88	4
5	Nurse Aides & Orderlies	71,280	78,355	801,095	10.22	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,489	2,870	32,560	11.34	8
9	Activity Director	1,969	2,171	29,157	13.43	9
10	Activity Assistants	4,018	4,734	40,929	8.65	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,883	2,027	116,204	57.33	20
21	Assistant Administrator		62	793	12.79	21
22	Other Administrative	6,515	7,303	103,627	14.19	22
23	Office Manager	1,977	2,218	45,182	20.37	23
24	Clerical	3,787	4,285	56,937	13.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Prof Coordinator	5,484	6,083	86,618	14.24	33
34	TOTAL (lines 1 - 33)	142,681	157,739	\$ 2,156,688 *	\$ 13.67	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	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	2	3
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference
50	Registered Nurses	\$	50
51	Licensed Practical Nurses		51
52	Nurse Aides		52
53	TOTAL (lines 50 - 52)	\$	53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Illini Hospital Nursing Home**

# **0037143**

Report Period Beginning: **7/1/03**

Ending: **6/30/04**

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Barbra Mask (pg 3)			\$ 98,599	Workers' Compensation Insurance	\$ 347	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes	164,816	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	55,737	Subscrip 68210-64050	327	
				Employee Meals		Subscrip 68310-64050	226	
				Illinois Municipal Retirement Fund (IMRF)*		Dues 80010-64000	3,804	
				Pension	64,769	Subscrip 80010-64050	49	
				Life Insurance	4,346	Adv 84710-62000	487	
				LT Disability	15,274	Subscrip 84710-64050	1,650	
				EAP	2,978	Less: Public Relations Expense	( )	
				Employee Physicals	3,084	Non-allowable advertising	( )	
				Misc	3,782	Yellow page advertising	( )	
				Employee Prescriptions	26,750			
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 6,543	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 98,599	TOTAL (agree to Schedule V, line 22, col.8)	\$ 341,883			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Other 80010-69990			\$ 4,300				Out-of-State Travel	\$
Freight 80010-6110			536					
Outside Service 80010 54000			174				In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 5,010				Seminar Expense	6,629
C. Professional Services								
Vendor/Payee	Type		Amount				Entertainment Expense	( )
Illini Hosp 80010-54800	Mgmt Svc		\$ 64,538				(agree to Sch. V, line 24, col. 8)	
Illini Hosp 80010-45000	Professional		13,234				TOTAL	\$ 6,629
Illini Hosp 80030-54800	Mgmt Svc		1,228					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 79,000	TOTAL		\$		

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**  
 (See instructions.)

1	2	3	4	5										
				6										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	
2			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Illini Hospital Nursing Home# 0037143Report Period Beginning: 7/1/03Ending: 6/30/04**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IL Council on LTC \$3,704
- (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? N/A
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 20,268 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. N/A
- (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 of Public Aid during this cost report period. \$ 0  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, 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. \$ Yes Has any meal income been offset against related costs? Net in Alloc Indicate the amount. \$ 0
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? Yes  
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. \$ N/A  
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.** \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: McGladrey & Pullen, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**

**Illini Hospital Nursing Home**

**FYE: 6/30/04**

**Detail of Travel & Seminar Expense**

Expense per Schedule V, Line 24 \$ 6,629

<u>Acct</u>	<u>Description</u>	<u>Amount</u>
74.68110-64300	Edu & Travel-Nursing	1,132
74.68210-64300	Edu & Travel-Nursing	1,462
74.68310-64300	Edu & Travel-Nursing	199
74.74810-64300	Edu & Travel-Social Svc	166
74.80010-64300	Edu & Travel-Admin	317
74.80410-64300	Edu & Travel-Clerical	2,524
74.80610-64300	Edu & Travel-Activities	694
74.86610-64300	Edu & Travel-Clerical	136
		<u><u>\$ 6,629</u></u>