

		FOR BHF USE				

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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

I. IDPH Facility ID Number: 0037143

Facility Name: Illini Hospital Nursing Home

Address: 1455 Hospital Road Silvis 61282
 Number City Zip Code

County: Rock Island

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

HFS ID Number: 36-3616314001

Date of Initial License for Current Owners: 8/12/91

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Mike Caddick **Telephone Number:** (708) 466-7240

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2005 to 06/30/2006 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) <u>Leo Bressanelli</u>	
	(Title) <u>Chief Executive Officer, Genesis Health System</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Michael Caddick</u> <u>Manager</u>	
	(Firm Name & Address) <u>Strategic Reimbursement, Inc.</u> <u>3315 W. Algonquin Rd. Rolling Meadows, IL 60008</u>	
	(Telephone) <u>(708) 466-7240</u> Fax # <u>(847) 259-9869</u>	
	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 Hospital Nursing Home

0037143 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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	<u>22</u>	Skilled (SNF)	<u>22</u>	<u>8,030</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>53</u>	Intermediate (ICF)	<u>53</u>	<u>19,345</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>45</u>	ICF/DD 16 or Less	<u>53</u>	<u>16,425</u>	6
7	<u>120</u>	TOTALS	<u>128</u>	<u>43,800</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF		<u>751</u>	<u>6,453</u>	<u>7,204</u>	8
9	SNF/PED					9
10	ICF	<u>6,990</u>	<u>11,378</u>		<u>18,368</u>	10
11	ICF/DD					11
12	SC		<u>15,355</u>		<u>15,355</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>6,990</u>	<u>27,484</u>	<u>6,453</u>	<u>40,927</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.44%

D. How many bed-hold days during this year were paid by the Department? 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 8/12/1991

J. Was the facility purchased or leased after January 1, 1978?
YES Date 8/12/1991 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 6,257

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.

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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

	Operating Expenses	Costs 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
	A. General Services										
1	Dietary			737	737	737	(1,072)	(335)			1
2	Food Purchase		1,173,717		1,173,717	1,173,717	(680,866)	492,851			2
3	Housekeeping		15,537	239,442	254,979	254,979	(118,472)	136,507			3
4	Laundry						191,191	191,191			4
5	Heat and Other Utilities			148,432	148,432	148,432		148,432			5
6	Maintenance		9,744	131,379	141,123	141,123	(257,894)	(116,771)			6
7	Other (specify):*						108,162	108,162			7
8	TOTAL General Services		1,198,998	519,990	1,718,988	1,718,988	(758,951)	960,037			8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,930,682	24,374	149,959	2,105,015	2,105,015		2,105,015			10
10a	Therapy		29	289,606	289,635	289,635		289,635			10a
11	Activities	73,155	7,539	7,393	88,087	88,087		88,087			11
12	Social Services	66,017	630	1,800	68,447	68,447		68,447			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,069,854	32,572	448,758	2,551,184	2,551,184		2,551,184			16
	C. General Administration										
17	Administrative	244,669	5,465	753,850	1,003,984	1,003,984	(637)	1,003,347			17
18	Directors Fees										18
19	Professional Services			528,821	528,821	528,821		528,821			19
20	Dues, Fees, Subscriptions & Promotions			13,010	13,010	13,010	(5,550)	7,460			20
21	Clerical & General Office Expenses	53,082	1,035	5,484	59,601	59,601	429,014	488,615			21
22	Employee Benefits & Payroll Taxes			721,945	721,945	721,945	29,487	751,432			22
23	Inservice Training & Education										23
24	Travel and Seminar			4,945	4,945	4,945		4,945			24
25	Other Admin. Staff Transportation			287	287	287		287			25
26	Insurance-Prop.Liab.Malpractice										26
27	Other (specify):*										27
28	TOTAL General Administration	297,751	6,500	2,028,342	2,332,593	2,332,593	452,314	2,784,907			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,367,605	1,238,070	2,997,090	6,602,765	6,602,765	(306,637)	6,296,128			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 Hospital Nursing Home #0037143 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			294,198	294,198		294,198	145,106	439,304			30
31	Amortization of Pre-Op. & Org.			8,963	8,963		8,963		8,963			31
32	Interest			552,853	552,853		552,853	(32,136)	520,717			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			9,290	9,290		9,290		9,290			35
36	Other (specify):*											36
37	TOTAL Ownership			865,304	865,304		865,304	112,970	978,274			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			293,887	293,887		293,887		293,887			39
40	Barber and Beauty Shops			80	23,584		23,584	(23,430)	154			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		293,967	23,504	317,471		317,471	(23,430)	294,041			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,367,605	1,532,037	3,885,898	7,785,540		7,785,540	(217,097)	7,568,443			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 Hospital Nursing Home

0037143

Report Period Beginning: 07/01/2005

Ending: 06/30/2006

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	(1,072)	1		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				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	(265)	17		17
18	Fines and Penalties				18
19	Entertainment	(23,430)	40		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	(5,550)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(18,051)	32		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (48,368)		\$	30

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)	(154,644)		34
35	Other- Attach Schedule	(14,085)	32	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (168,729)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (217,097)		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Illini Hospital Nursing Home

ID# 0037143

Report Period Beginning: 07/01/2005

Ending: 06/30/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Illini Hospital Nursing Home

0037143

Report Period Beginning:

07/01/2005

Ending:

06/30/2006

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(1,072)	0	0	0	0	0	0	0	0	0	0	(1,072)	1
2	Food Purchase	0	(680,866)	0	0	0	0	0	0	0	0	0	(680,866)	2
3	Housekeeping	0	(118,472)	0	0	0	0	0	0	0	0	0	(118,472)	3
4	Laundry	0	191,191	0	0	0	0	0	0	0	0	0	191,191	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	(257,894)	0	0	0	0	0	0	0	0	0	(257,894)	6
7	Other (specify):*	0	108,162	0	0	0	0	0	0	0	0	0	108,162	7
8	TOTAL General Services	(1,072)	(757,879)	0	(758,951)	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	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(265)	(372)	0	0	0	0	0	0	0	0	0	(637)	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	(5,550)	0	0	0	0	0	0	0	0	0	0	(5,550)	20
21	Clerical & General Office Expenses	0	429,014	0	0	0	0	0	0	0	0	0	429,014	21
22	Employee Benefits & Payroll Taxes	0	29,487	0	0	0	0	0	0	0	0	0	29,487	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	TOTAL General Administration	(5,815)	458,129	0	452,314	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(6,887)	(299,750)	0	(306,637)	29								

STATE OF ILLINOIS

Facility Name & ID Number Illini Hospital Nursing Home# 0037143

Report Period Beginning:

07/01/2005 Ending:

Summary B

06/30/2006

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)	
	D. Ownership													
30	Depreciation	0	145,106	0	0	0	0	0	0	0	0	0	145,106	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(32,136)	0	0	0	0	0	0	0	0	0	0	(32,136)	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	(32,136)	145,106	0	112,970	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	(23,430)	0	0	0	0	0	0	0	0	0	0	(23,430)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(23,430)	0	0	0	0	0	0	0	0	0	0	(23,430)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(62,453)	(154,644)	0	(217,097)	45								

Facility Name & ID Number Illini Hospital Nursing Home

0037143

Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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 Restoritive Care Center	Silvis	Illini Hospital	Silvis	Hospital
				Crosstown Square	Silvis	Senior Apts
				Genesis Health System	Davenport, IA	Hoem 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	\$ 686,990	Illini Hospital (B Pt. 1 allocated cost)	100.00%	\$ 716,477	\$ 29,487	1
2	V	17		Illini Hospital (B Pt. 1 allocated cost)	100.00%			2
3	V	4 Linen		Illini Hospital (B Pt. 1 allocated cost)	100.00%	191,191	191,191	3
4	V	3 Housekeeping	254,979	Illini Hospital (B Pt. 1 allocated cost)	100.00%	136,507	(118,472)	4
5	V	2 Dietary	1,176,160	Illini Hospital (B Pt. 1 allocated cost)	100.00%	495,294	(680,866)	5
6	V	7 Cafeteria		Illini Hospital (B Pt. 1 allocated cost)	100.00%	108,162	108,162	6
7	V	17 Central Processing	373	Illini Hospital (B Pt. 1 allocated cost)	100.00%	1	(372)	7
8	V	30 CRC Buildings & Fixt.	853,594	Illini Hospital (B Pt. 1 allocated cost)	100.00%	998,700	145,106	8
9	V	21 IRC Admin & General	1,542,606	Illini Hospital (B Pt. 1 allocated cost)	100.00%	1,971,620	429,014	9
10	V	6 Plant Operations	474,599	Illini Hospital (B Pt. 1 allocated cost)	100.00%	216,705	(257,894)	10
11	V	10 Nursing Administration	117,360	Illini Hospital (B Pt. 1 allocated cost)	100.00%	117,360		11
12	V	12 Social Service	68,482	Illini Hospital (B Pt. 1 allocated cost)	100.00%	68,482		12
13	V	11 Activity	89,722	Illini Hospital (B Pt. 1 allocated cost)	100.00%	89,722		13
14	Total		\$ 5,264,865			\$ 5,110,221	\$ * (154,644)	14

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

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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			NOT APPLICABLE							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 Hospital Nursing Home

0037143 Report Period Beginning: 07/01/2005

Ending: 6/30/2006

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 Illini Hospital
 Street Address 801 Hospital Road
 City / State / Zip Code Silvis, Il. 61282
 Phone Number (309) 792-4268
 Fax Number (309) 792-4274

1	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	Benefits	Salaries	20,338,586	3	\$ 6,084,382	\$ 273,793	2,395,005	\$ 716,477	1
2	17	Admin & General	Accum Cost	47,725,371	3	14,025,727		6,708,837	1,971,620	2
3	4	Linen	Linen Lbs	786,025	3	674,001		222,968	191,191	3
4	3	Housekeeping	Sq. Ft.	153,579	3	1,061,390		19,752	136,507	4
5	2	Dietary	Meals	416,315	3	1,630,051		126,498	495,294	5
6	7	Cafeteria	FTE's	42,909	3	700,020		6,630	108,162	6
7	15	Central Service	Costed Req.	5,947,377	3	1,632,391		0	0	7
8	30	Depr Building/Fixt.	Sq. Ft.	51,538	3	1,160,616		44,348	998,700	8
9	17	IRC Admin	Accum Cost		3					9
10	6	Plant Operations	Sq. Ft.	49,295	3	240,877		44,348	216,704	10
11	10	Nursing Admin	Nsg Hrs	10,000	3	117,360		10,000	117,360	11
12	12	Social Service	IRC Discharges	1,000	3	68,482		1,000	68,482	12
13	11	Activity	Days	1,000	3	89,722		1,000	89,722	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					\$ 27,485,019	\$ 273,793		\$ 5,110,219	25

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		X	Mortgage	Varies	6/26/06	\$ 11,000,000	\$ 11,000,000	7/2007	0.0690	\$ 552,853	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related					\$ 11,000,000	\$ 11,000,000			\$ 552,853	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$ 11,000,000	\$ 11,000,000			\$ 552,853	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 44,535 Line # 17

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

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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 Bureau of Health Finance at (217) 782-1630.

2005 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 2005 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 2005.

(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. _____	NOT APPLICABLE	\$ _____	\$ _____
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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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 Hospital Nursing Home

0037143 Report Period Beginning:

07/01/2005 Ending:

06/30/2006

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	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

Facility Name & ID Number Illini Hospital Nursing Home

0037143

Report Period Beginning:

07/01/2005

Ending:

06/30/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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		2004		\$ 11,159,141	\$ 367,310	40	\$ 367,310	\$	\$ 2,305,010	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Land Improvement - 10 Year #1,#2,#102,#189		1991	12,671		10			12,671	9
10		Land Improvement 15 #187		1991	22,738	1,516	15	1,516		21,222	10
11		Carpet #239		1992	438		5			438	11
12		Vinly Flooring # 240		1992	578	29	20	29		346	12
13		Chandelier #241		1992	492		10			492	13
14		Wallpaper #244		1992	2,326		5			2,326	14
15		Singage # 243		1993	1,305	109	12	109		1,196	15
16		Alarm System, 3 247		1992	587	39	15	39		470	16
17		Smoke Door Hood #249		1992	779		10			779	17
18		Central Dumpster #250		1992	465		10			465	18
19		New Seeding/Mulch #261,#262		1993	10,415		10			10,415	19
20		Repair Sidewalk #274		1994	1,874	125	15	125		1,249	20
21		Circuit Panel A/C Outlet #265		1993	930		10			930	21
22		Install A/C #275		1994	498	50	10	50		498	22
23		FY additions #278,#292, #294		1995	5,072	338	15	338		4,113	23
24		PT Therapy Utility Construction # 305		1996	122,757	8,184	15	8,184		70,046	24
25		Canvas Awning #306 & Decorative Lighting #307		1996	20,660	1,377	15	1,377		15,221	25
26		Emerson # 308		1996	594	59	10	59		476	26
27		Parking Lot Repair #317		1997	3,561		10			3,561	27
28		Major Repair IRC Boiler #319		1997	6,872	982	7	982		9,444	28
29		Directory Board # 327		1997	797		5			797	29
30		Remodel IRC Nurse Station #330		1997	3,340	223	15	223		1,556	30
31		Cabinets-Storage-Utility Room #331		1997	4,103	274	15	274		1,911	31
32		Carpet # 329		1997	1,440		5			1,440	32
33		Hot Water Tank # 328		1997	1,749		5			1,749	33
34		Tank #312		1996	2,650	265	10	265		2,120	34
35		Air Compressor for Chiller #335		1997	11,196	746	15	746		6,428	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 Hospital Nursing Home

0037143

Report Period Beginning:

07/01/2005 Ending: 06/30/2006

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	\$	\$ 1,196	37
38	Landscaping #352	1999	2,176	218	10	218		1,306	38
39	Carpet Lobby & Office Area #361	1999	2,123	425	5	425		2,548	39
40	Tie-In Peeping Hot Water to IRC #372	1999	1,766	88	20	88		530	40
41	Install VPI Bse & Ceramic Tile #376	1999	1,385	139	10	139		832	41
42	Lock Sets mastered to Key 3349	2000	2,642	528	5	528		3,170	42
43	Wook Replacement doors # 388	2000	1,308	65	20	65		327	43
44	4" Sprinkler System #397	2001	12,675	507	25	507		2,535	44
45	Concrete Replacement #444	2001	2,239	112	20	112		448	45
46	IRC Roof Hathces #435	2001	2,420	242	10	242		968	46
47	door and Door Closers Exam Room #440	2001	1,524	76	20	76		305	47
48	Activites Office-Paint, Wallpper, Carpet #442	2001	1,926	385	5	385		1,541	48
49	Carpentry Patient Room Showers #443	2001	6,326	316	20	316		1,265	49
50	Air Cond./Handling Unit3-Way Control Val #433	2001	2,187	219	10	219		875	50
51	IRC Boiler Stack #438	2001	11,750	588	20	588		2,351	51
52	PA System, IRC Dining Room #439	2001	1,682	168	10	168		673	52
53	Date Voice Wiring-SC #412	2001	21,453	2,145	10	2,145		8,581	53
54	Door Alarm-Sc #413	2001	2,211	221	10	221		884	54
55	Analog Message-SC #413	2001	2,693	269	10	269		1,077	55
56	Phone System -SC	2001	19,440	1,944	10	1,944		7,776	56
57	Nurse Call System Sc #436	2001	6,498	650	10	650		2,599	57
58	Kitchen Cabinets S #437	2001	4,077	272	15	272		1,087	58
59	Refrigerator, Washer, Drver-SC \$4221,423, 424	2001	1,665	111	15	111		444	59
60	Phones Sc #423, 427, 428	2001	4,224	845	5	845		3,379	60
61	Beautv Shop Sc #425	2001	1,621	162	10	162		648	61
62	Parking Lot-NW Area-Asphalt & Lights #462, 463	2002	43,929	4,393	10	4,393		13,179	62
63	IRC Building Improve #451, 453, 454, 455,456, 510	2002	17,485	1,749	10	1,749		5,246	63
64	IRC Hallway Carpet #464	2002	10,072	2,014	5	2,014		6,043	64
65	IRC Wooken Door #455, Bedpan Washers #450	2002	4,388	219	20	219		658	65
66	IRC Switchboard cable #458, Boiler Fail over #461	2002	6,736	449	15	449		1,347	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 11,603,405	\$ 401,329		\$ 401,329	\$	\$ 2,551,187	70

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

Facility Name & ID Number Illini Hospital Nursing Home

0037143

Report Period Beginning:

07/01/2005 Ending: 06/30/2006

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	\$ 401,329		\$ 401,329	\$	\$ 2,551,187	1
2									2
3	Security system # 513	2003	5,267	351		351		702	3
4	IRC Loading #626	2003	87,613	4,381		4,381		8,762	4
5	Parking garage #518	2003	10,364	518		518		1,036	5
6	Bronze Cir #512	2003	1,937	194		194		388	6
7	Air Cond. #516	2003	2,755	276		276		552	7
8	IRC Door Alarm #517	2003	4,792	479		479		958	8
9	Boiler Replacement Deaerator	2005	18,280	1,219		1,219		1,829	9
10	Air/Dirt Separator	2005	4,905	491		491		736	10
11	Heating/Colling Valves	2005	30,935	3,094		3,094		4,298	11
12	Valve Replacement	2005	10,280	1,028		1,028		1,542	12
13	Replaced Carpet 2nd Level	2005	20,215	4,043		4,043		6,064	13
14	Lined Drapes	2005	6,224	1,245		1,245		1,867	14
15	Roof	2006	51,860	3,457		3,457		3,457	15
16	Acuator Controls	2006	4,092	136		136		136	16
17	Valve Replacement	2006	12,432	414		414		414	17
18	Conduit & wiring	2006	1,539	51		51		51	18
19	Remodeling of Corridors and Public Areas	2006	199,131	13,275		13,275		13,275	19
20	Landscaping	2006	2,511	168		168		168	20
21	Design Fees	2006	15,555	1,037		1,037		1,037	21
22	Heatinh & Cooling Valves	2006	13,716	610		610		610	22
23	Heatinh & Cooling Valves	2006	8,631	384		384		384	23
24	Design Fees	2006	1,601	107		107		107	24
25	Hollow Metal Doors	2006	10,987	366		366		366	25
26	Drapes	2006	2,304	308		308		308	26
27	Artwork	2006	5,147	343		343		343	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,136,478	\$ 439,304		\$ 439,304	\$	\$ 2,600,577	34

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

Facility Name & ID Number Illini Hospital Nursing Home # 0037143 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	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 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 12,194,201	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 439,304	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 439,304	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)	\$ 2,600,577	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				NOT APPLICABLE			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: _____*

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: \$ 9,290 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

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

* 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 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.)

<p>1. HAVE YOU TRAINED CNAs 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. <u>CLASSROOM PORTION:</u></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 CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	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			12,650			12,650	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			276,956			276,956	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				165,005		165,005	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$ 289,606	\$ 165,005		\$ 454,611	14

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

Facility Name & ID Number Illini Hospital Nursing Home# 0037143Report Period Beginning: 07/01/2005

Ending:

06/30/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2006

(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	\$ 1,747,417	\$	1
2	Cash-Patient Deposits	1,556		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	751,180		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,278		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	6,124		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,530,555	\$	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	12,125,392		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,568,550		16
17	Accumulated Depreciation (book methods)	(5,954,767)		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): <u>Construction in Progress</u>	140,247		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,937,145	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,467,700	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 328,248	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	247,359		29
30	Accrued Salaries Payable	247,295		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>accrued expenses</u>	109,704		36
37	<u>third party settlements</u>	49,448		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 982,054	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	10,752,641		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Other I.T. Liab</u>	5,574		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 10,758,215	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 11,740,269	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,272,569)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,467,700	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,756,880)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,756,880)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	484,311	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 484,311	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,272,569)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Illini Hospital Nursing Home# 0037143Report Period Beginning: 07/01/2005Ending: 06/30/2006**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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,067,845	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,067,845	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		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	1,480,916	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,480,916	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	other revenue	176,788	28
28a	<u>Gain on retirement of debt</u>	478,902	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 655,690	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,204,451	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,533,813	31
32	Health Care	2,962,539	32
33	General Administration	2,791,095	33
B. Capital Expense			
34	Ownership		34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38	<u>non-allowable costs (excluded from C/R)</u>	1,432,693	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,720,140	40
41	Income before Income Taxes (line 30 minus line 40)**	484,311	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 484,311	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.

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

Facility Name & ID Number Illini Hospital Nursing Home

0037143

Report Period Beginning: 07/01/2005

Ending:

06/30/2006

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	3,691	4,166	\$ 104,261	\$ 25.03	1
2	Assistant Director of Nursing	1,822	1,949	45,648	23.42	2
3	Registered Nurses	13,697	15,157	377,679	24.92	3
4	Licensed Practical Nurses	26,033	29,285	520,496	17.77	4
5	CNAs & Orderlies	65,149	72,589	810,356	11.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,841	4,103	48,454	11.81	8
9	Activity Director	1,845	2,107	29,608	14.05	9
10	Activity Assistants	4,790	5,333	51,844	9.72	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	1,920	2,086	100,164	48.02	20
21	Assistant Administrator					21
22	Other Administrative	1,103	1,312	23,398	17.83	22
23	Office Manager	1,897	2,005	47,874	23.88	23
24	Clerical	3,586	3,994	56,892	14.24	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,962	3,195	40,035	12.53	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	5,382	6,274	110,896	17.68	33
34	TOTAL (lines 1 - 33)	137,718	153,555	\$ 2,367,605 *	\$ 15.42	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	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number Illini Hospital Nursing Home

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Report Period Beginning: 07/01/2005

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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	
Roger Brannan	Administrator		\$ 96,048	Workers' Compensation Insurance	\$	IDPH License Fee	\$	
Other Administrative			148,621	Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes		Health Care Worker Background Check		
				Employee Health Insurance		(Indicate # of checks performed _____)		
				Employee Meals		Dues	4,896	
				Illinois Municipal Retirement Fund (IMRF)*		Subscriptions	2,564	
						Advertising Promotions	5,550	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 244,669	See attached	751,433			
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount					
Corporate Home Office allocations			\$ 595,071				Less: Public Relations Expense ()	
Insurance			75,903				Non-allowable advertising (5,550)	
Hospital Allocations			38,190				Yellow page advertising ()	
Other Administrative (See Attached)			44,686					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 753,850					
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description			Description	
Vendor/Payee	Type		Amount	Line #	Amount		Amount	
Auditing Fees	Auditing		\$ 34,850		\$	Out-of-State Travel	\$	
Accounting Fees - Related	Accounting		487,676					
Accounting Fees	Accounting		715			In-State Travel		
Legal Fees	Legal Fees		812					
Consulting/Professional	Consulting		4,768			Seminar Expense	4,945	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 528,821				\$ 4,945	

* Attach copy of IMRF notifications

**See instructions.

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. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 25,831 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 No NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO No If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ No
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? _____ Indicate the amount. \$ 2,261
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (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.