

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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

I. IDPH License ID Number: 0048264

Facility Name: Illini Restorative Care

Address: 1455 Hospital Road 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 07/01/2006 to 06/30/2007 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) _____	
	(Title) _____	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Michael Caddick</u> <u>Vice President</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 Restorative Care

0048264 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

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>45</u>	<u>16,425</u>	6
7	<u>120</u>	TOTALS	<u>120</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>1,025</u>	<u>6,204</u>	<u>7,229</u>	8
9	SNF/PED					9
10	ICF	<u>7,934</u>	<u>10,609</u>		<u>18,543</u>	10
11	ICF/DD					11
12	SC		<u>15,488</u>		<u>15,488</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,934</u>	<u>27,122</u>	<u>6,204</u>	<u>41,260</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.20%

D. How many bed-hold days during this year were paid by the Department? _____ (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 08/12/1991

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ 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 6,204

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 Restorative Care # 0048264 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary			1,092	1,092		1,092		1,092		1
2	Food Purchase		641,491		641,491		641,491	(403,991)	237,500		2
3	Housekeeping		15,129	245,834	260,963		260,963	(88,431)	172,532		3
4	Laundry							167,522	167,522		4
5	Heat and Other Utilities										5
6	Maintenance	164	12,310	280,071	292,545		292,545	(59,152)	233,393		6
7	Other (specify):*							175,762	175,762		7
8	TOTAL General Services	164	668,930	526,997	1,196,091		1,196,091	(208,290)	987,801		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,917,437	19,271	129,540	2,066,248		2,066,248		2,066,248		10
10a	Therapy		9	322,192	322,201		322,201	(48,401)	273,800		10a
11	Activities	67,846	4,107	9,952	81,905		81,905		81,905		11
12	Social Services	65,232	297	22,137	87,666		87,666		87,666		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,050,515	23,684	483,821	2,558,020		2,558,020	(48,401)	2,509,619		16
	C. General Administration										
17	Administrative	245,019	5,104	606,904	857,027		857,027	348,046	1,205,073		17
18	Directors Fees										18
19	Professional Services			549,491	549,491		549,491		549,491		19
20	Dues, Fees, Subscriptions & Promotions			15,209	15,209		15,209	(7,406)	7,803		20
21	Clerical & General Office Expenses	61,065	699		61,764		61,764		61,764		21
22	Employee Benefits & Payroll Taxes			652,636	652,636		652,636	25,277	677,913		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,271	5,271		5,271		5,271		24
25	Other Admin. Staff Transportation			649	649		649		649		25
26	Insurance-Prop.Liab.Malpractice										26
27	Other (specify):*										27
28	TOTAL General Administration	306,084	5,803	1,830,160	2,142,047		2,142,047	365,917	2,507,964		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,356,763	698,417	2,840,978	5,896,158		5,896,158	109,226	6,005,384		29

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

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

Facility Name & ID Number Illini Restorative Care #0048264 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			283,961	283,961		283,961		283,961		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			564,221	564,221		564,221	(28,755)	535,466		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			848,182	848,182		848,182	(28,755)	819,427		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		6,608	279,710	286,318		286,318		286,318		39
40	Barber and Beauty Shops		80	23,363	23,443		23,443	(23,443)			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee										42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		6,688	303,073	309,761		309,761	(23,443)	286,318		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,356,763	705,105	3,992,233	7,054,101		7,054,101	57,028	7,111,129		45

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

Facility Name & ID Number Illini Restorative Care

0048264

Report Period Beginning:

07/01/2006

Ending:

06/30/2007

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,155)	3		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(48,401)	10A		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(14,670)	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	(23,443)	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	(7,406)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	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)	166,188		34
35	Other- Attach Schedule	(14,085)	32	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 152,103		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 152,103		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 Restorative Care

ID# 0048264

Report Period Beginning: 07/01/2006

Ending: 06/30/2007

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Illini Restorative Care

0048264

Report Period Beginning:

07/01/2006

Ending:

06/30/2007

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	(403,991)	0	0	0	0	0	0	0	0	0	(403,991)	2
3	Housekeeping	(1,155)	(87,276)	0	0	0	0	0	0	0	0	0	(88,431)	3
4	Laundry	0	167,522	0	0	0	0	0	0	0	0	0	167,522	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	(59,152)	0	0	0	0	0	0	0	0	0	(59,152)	6
7	Other (specify):*	0	175,762	0	0	0	0	0	0	0	0	0	175,762	7
8	TOTAL General Services	(1,155)	(207,135)	0	(208,290)	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	(48,401)	0	0	0	0	0	0	0	0	0	0	(48,401)	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	(48,401)	0	0	0	0	0	0	0	0	0	0	(48,401)	16
	C. General Administration													
17	Administrative	0	348,046	0	0	0	0	0	0	0	0	0	348,046	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	(7,406)	0	0	0	0	0	0	0	0	0	0	(7,406)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	25,277	0	0	0	0	0	0	0	0	0	25,277	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	(7,406)	373,323	0	365,917	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(56,962)	166,188	0	109,226	29								

STATE OF ILLINOIS

Facility Name & ID Number Illini Restorative Care

0048264

Report Period Beginning:

07/01/2006 Ending:

Summary B

06/30/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(28,755)	0	0	0	0	0	0	0	0	0	0	(28,755)	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	(28,755)	0	0	0	0	0	0	0	0	0	0	(28,755)	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	(23,443)	0	0	0	0	0	0	0	0	0	0	(23,443)	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	(23,443)	0	0	0	0	0	0	0	0	0	0	(23,443)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(109,160)	166,188	0	57,028	45								

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	Hospital
				Crosstown Square	Silvis	Senior Apts.
				Genesis Health Sys.	Davenport	Home Office+Y2

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	\$ 721,945	Illini Hospital (B pt. 1 allocated cost)	100.00%	\$ 747,222	\$ 25,277 1
2	V	17 Administrative & General	1,532,805	Illini Hospital (B pt. 1 allocated cost)	100.00%	1,880,851	348,046 2
3	V	4 Linen		Illini Hospital (B pt. 1 allocated cost)	100.00%	167,522	167,522 3
4	V	3 Housekeeping	254,979	Illini Hospital (B pt. 1 allocated cost)	100.00%	167,703	(87,276) 4
5	V	2 Dietary	1,173,717	Illini Hospital (B pt. 1 allocated cost)	100.00%	769,726	(403,991) 5
6	V	7 Cafeteria		Illini Hospital (B pt. 1 allocated cost)	100.00%	175,762	175,762 6
7	V	17 Central Processing		Illini Hospital (B pt. 1 allocated cost)	100.00%		
8	V	30 CRC Buildings & Fixtures	294,198	Illini Hospital (B pt. 1 allocated cost)	100.00%	294,198	
9	V	21 IRC Admin & General		Illini Hospital (B pt. 1 allocated cost)	100.00%		
10	V	6 Plant Operations	289,555	Illini Hospital (B pt. 1 allocated cost)	100.00%	230,403	(59,152) 10
11	V	10 Nursing Administration	116,568	Illini Hospital (B pt. 1 allocated cost)	100.00%	116,568	
12	V	12 Social Service	87,666	Illini Hospital (B pt. 1 allocated cost)	100.00%	87,666	
13	V	11 Activity	81,905	Illini Hospital (B pt. 1 allocated cost)	100.00%	81,905	
14	Total		\$ 4,553,338			\$ 4,719,526	\$ * 166,188 14

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

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

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			NOT APPLICABLE								5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Illini Restorative Care

0048264 Report Period Beginning: 07/01/2006

Ending: 6/30/2007

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	Employee Benefits	Salaries	3	\$ 6,550,990	\$	2,367,605	\$ 747,222	1
2	17	Administrative & General	Accum. Cost	3	10,919,235		7,785,540	1,880,851	2
3	4	Linen	Linen Lbs	3	617,799		210,533	167,522	3
4	3	Housekeeping	Sq. Ft.	3	1,388,856		19,752	167,703	4
5	2	Dietary	Meals	3	2,551,242		129,400	769,726	5
6	7	Cafeteria	FTE's	3	1,017,764		7,316	175,762	6
7	17	Central Processing	Costed Req.	3	1,141,945			0	7
8	30	CRC Buildings & Fixtures	SQ. Ft.	3	552,193		50,325	539,197	8
9				3					9
10	6	Plant Operations	Sq. Ft.	3	236,216		48,082	230,403	10
11	10	Nursing Administration	Nsg Hrs	3	116,568		10,000	116,568	11
12	12	Social Service	IRC Discharges	3	87,666		1,000	87,666	12
13	11	Activity	Days	3	81,905		1,000	81,905	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 25,262,379	\$		\$ 4,964,525	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	6/28/06	\$ 11,000,000	\$ 10,752,681	7/2011	0.0690	\$ 564,221	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related					\$ 11,000,000	\$ 10,752,681			\$ 564,221	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	\$ 10,752,681			\$ 564,221	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 22,189 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.)

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2006 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 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	<u>NOT APPLICABLE</u>	8
	2003	_____	9
	2004	_____	10
	2005	_____	11
	2006	_____	12
FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Illini Restorative Care COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0048264

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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. _____	NOT APPLICABLE	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number Illini Restorative Care

0048264 Report Period Beginning:

07/01/2006 Ending:

06/30/2007

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 Restorative Care

0048264

Report Period Beginning:

07/01/2006 Ending: 06/30/2007

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120		1991		\$ 584,661	\$ 13,398	40	\$ 13,398		\$ 236,301	4
5			2000		5,435,418	124,562	40	124,562		917,227	5
6											6
7											7
8											8
	Improvement Type**										
9	Electrical Feed		1991		1,209	56	20	56		975	9
10	Architect Fees		1991		89,731	2,056	40	2,056		36,266	10
11	Field Tests		1991		1,547	35	40	35		625	11
12	Time & Material Work		1991		17,753	407	40	407		7,175	12
13	Kitchen Plan		1991		1,025	23	40	23		414	13
14	Heating/Ventilation/Air Conditioning		1991		27,371	627	40	627		11,062	14
15	Pipe Recepticals		1991		7,746	284	25	284		5,009	15
16	Kitchen & Lounge		1991		40,623	931	40	931		16,419	16
17	Copper Wire		1991		3,981	182	20	182		3,218	17
18	Sewer Line		1991		18,770	860	20	860		15,173	18
19	Elevator Auto Ret. Sy		1991		1,042	48	20	48		843	19
20	Sheet Metal		1991		3,843	176	20	176		3,106	20
21	Wood Door Frames/Hardware		1991		53,541	2,454	20	2,454		43,279	21
22	Metal Windows		1991		13,134	602	20	602		10,617	22
23	Aluminum Entrance		1991		7,608	349	20	349		6,149	23
24	Ceramic Tile		1991		3,575	164	20	164		2,890	24
25	Pumbing/Sprinkler work		1991		211,741	9,705	20	9,705		171,157	25
26	Heating		1991		157,820	8,510	18	8,510		150,084	26
27	Air Conditioning		1991		133,565	7,202	18	7,202		127,017	27
28	Electrical		1991		128,975	5,911	20	5,911		104,255	28
29	Plumbing&Electrical Util		1991		44,800	2,053	20	2,053		36,213	29
30	Building		1991		88,055	2,018	40	2,018		35,589	30
31	Vinyl		1992		578	27	20	27		438	31
32	Handrails. IRC		1994		5,358	327	15	327		4,554	32
33	PT Utility Study		1995		142,758	8,724	15	8,724		115,792	33
34	Air Compressor for Chiller		1997		14,196	868	15	868		8,991	34
35	Tie In Piping Hot Water to IRC		1998		1,766	81	20	81		743	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Illini Restorative Care

0048264

Report Period Beginning:

07/01/2006 Ending: 06/30/2007

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			\$	\$		\$	\$	\$	37
38	VPI Base & Ceramic Tile	1999	1,385	127	10	127		1,166	38
39	IRC Roof Hatches	2001	2,420	222	10	222		1,553	39
40	Door & Door Closers Exam Room	2001	1,523	93	15	93		652	40
41	Carpentry Patient Room Showers	2001	9,326	570	15	570		3,989	41
42	IRC Wall Hydrants	2002	1,354	124	10	124		733	42
43	IRC Wanderguard Relocation	2002	3,122	286	10	286		1,691	43
44	Medicare Rooms Wall Guards	2002	772	71	10	71		418	44
45	AHU Valve Control Upgrade	2002	3,328	305	10	305		1,802	45
46	IRC Cooling Unit Controls	2002	4,567	419	10	419		2,474	46
47	Sheltered Care Addition	2001	(196,204)	(4,496)	40	(4,496)		(29,022)	47
48	IRC Carpet Hallway	2002	10,072	1,007	5	1,007		10,072	48
49	Double Egress Door Replacement	2002	4,342	199	20	199		1,176	49
50	Scurity System	2003	6,267	575	10	575		2,768	50
51	IRC Loading Dock	2003	97,613	3,579	25	3,579		17,245	51
52	Architect Fees	2004	41,400	949	40	949		3,536	52
53	Blue Prints PT	2004	36	1	40	1		3	53
54	PT Construction	2004	80,180	1,837	40	1,837		6,849	54
55	PT Construction	2004	93,098	2,134	40	2,134		7,952	55
56	Wallcoverings	2004	490	90	5	90		335	56
57	Architect Fees IRC Laundry	2004	7,056	162	40	162		602	57
58	Blue Prints IRC Laundry	2004	122	3	40	3		10	58
59	Construction IRC Laundry	2004	24,446	560	40	560		2,088	59
60	Contact Services IRC Laundry	2004	60,362	1,383	40	1,383		5,156	60
61	RVS Architect Fees	2004	(1,655)	(38)	40	(38)		(141)	61
62	Blue Prints IRC Laundry	2004	(122)	(3)	40	(3)		(10)	62
63	Contact Services IRC Laundry	2004	(3,023)	(69)	40	(69)		(258)	63
64	Boiler Replacement Deaerator	2005	18,280	1,117	15	1,117		2,945	64
65	Air/Dirt Separator	2004	4,905	450	10	450		1,185	65
66	Roof	2005	51,860	4,754	10	4,754		7,347	66
67	Acuator Controls	2005	4,092	188	20	188		290	67
68	Valve Replacements	2006	12,432	570	20	570		881	68
69								109	69
70	TOTAL (lines 4 thru 69)		\$ 7,586,036	\$ 209,809		\$ 209,809	\$	\$ 2,127,177	70

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

Facility Name & ID Number Illini Restorative Care

0048264

Report Period Beginning:

07/01/2006 Ending: 06/30/2007

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		\$ 7,586,036	\$ 209,809		\$ 209,809	\$	\$ 2,127,177	1
2	Conduit & Wiring	2005	1,539	71	20	71		109	2
3	Construction	2005	199,131	18,254	10	18,254		28,210	3
4	Design Fees	2005	15,555	1,426	10	1,426		2,204	4
5	Heating & Cooling Valves	2005	13,716	838	15	838		1,295	5
6	Heating & Cooling Valves	2005	8,631	527	15	527		815	6
7	Design Fees	2006	1,601	147	10	147		227	7
8	Hollow Metal Doors	2006	10,987	504	20	504		778	8
9	Electric Switch Gear	2006	3,719	93	15	93		93	9
10	Cabinets/Casework	1991	23,231	1,065	20	1,065		18,778	10
11	Elevators	1991	13,665	626	20	626		11,046	11
12	Nurse Call System	1992	2,043	102	15	102		2,043	12
13	Handrail and Door	1992	1,470	74	15	74		1,470	13
14	Alarm System	1992	587	36	15	36		570	14
15	Remodel IRC Nurse Station	1997	3,340	204	15	204		2,245	15
16	Cabinets/Storage Util Room	1997	4,103	251	15	251		2,758	16
17	Double Egress Wood Doors	1998	2,756	168	15	168		1,669	17
18	Wood Replace Doors IRC	1999	1,308	80	15	80		647	18
19	4" Sprinkler	2000	18,675	685	25	685		5,540	19
20	Data Voice Wiring	2000	31,453	2,883	10	2,883		20,182	20
21	Door Alarm Sheltered Care	2000	2,211	203	10	203		1,419	21
22	Analog Message-Sheltered Care	2000	2,693	247	10	247		1,728	22
23	Phone System Shelterd Care	2000	25,643	2,351	10	2,351		16,454	23
24	Air Cind./Handling unit	2001	2,187	201	10	201		1,403	24
25	Nurse Call System SC	2001	6,498	596	10	596		4,169	25
26	Kitchen Cabinets SC	2001	4,077	249	15	249		1,744	26
27	IRC Boiler Stack	2001	14,750	676	20	676		4,732	27
28	PA System IRC Dining Room	2001	1,682	154	10	154		1,079	28
29	Door Wooden IRC	2001	1,465	90	15	90		529	29
30	IRC Bedpan Washers	2002	2,923	179	15	179		1,055	30
31	Switchboard Cable IRC	2002	4,831	443	10	443		2,617	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,012,506	\$ 243,232		\$ 243,232	\$	\$ 2,264,785	34

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

Facility Name & ID Number Illini Restorative Care

0048264

Report Period Beginning:

07/01/2006 Ending: 06/30/2007

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 12B, Carried Forward		\$ 8,012,506	\$ 243,232		\$ 243,232	\$	\$ 2,264,785	1
2	Boiler Fail Over Controls	2002	1,905	175	10	175		1,032	2
3	Bronze Circulating Pump	2003	1,937	178	10	178		855	3
4	Air Conditioning Unit	2003	2,755	361	7	361		1,738	4
5	IRC Door Alarm	2003	5,792	531	10	531		2,558	5
6	Canopy	2003	2,275	139	15	139		518	6
7	Air Handling IRC Laundry	2004	19,065	874	20	874		3,257	7
8	RVS Air Handling Cap	2004	(19,065)	(874)	20	(874)		(3,257)	8
9	Drapes (Fabric and Sheer)	2006	2,304	422	5	422		653	9
10	Repair Sidewalk	1994	1,874	115	15	115		1,655	10
11	Sidewalk	1995	710	43	15	43		588	11
12	Parking Lot Repairs	1996	3,561		8			3,561	12
13	Lanscaping IRC	1998	2,176	199	10	199		1,832	13
14	Concrete Replacement	2001	2,239	137	15	137		958	14
15	Asphalt Parking Lot NW Area	2002	44,394	5,087	8	5,087		30,059	15
16	Parking Lot Lights NW Area	2002	9,535	874	10	874		5,165	16
17	Lanscaping	2005	2,511	230	10	230		356	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)		\$ 8,096,474	\$ 251,723		\$ 251,723	\$	\$ 2,316,313	34

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

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

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	\$ 456,416	\$ 32,238	\$ 32,238	\$	14	\$ 231,030	71
72	Current Year Purchases	9,508					412	72
73	Fully Depreciated Assets	416,426					416,426	73
74								74
75	TOTALS	\$ 882,350	\$ 32,238	\$ 32,238	\$		\$ 647,868	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)	\$ 9,036,547	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 283,961	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 283,961	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)	\$ 2,964,181	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Illini Restorative Care

0048264

Report Period Beginning: 07/01/2006

Ending: 06/30/2007

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					NOT APPLICABLE			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: \$ _____ 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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

* 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			19,622			19,622	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			322,192			322,192	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				160,042		160,042	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			\$		\$ 341,814	\$ 160,042		\$ 501,856	14

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

Facility Name & ID Number Illini Restorative Care# 0048264Report Period Beginning: 07/01/2006

Ending:

06/30/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2007

(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	\$ 1,896,790	\$	1
2	Cash-Patient Deposits	1,200		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	676,134		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	9,804		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>due from Affiliates</u>	121,461		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,705,389	\$	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	12,123,095		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,743,505		16
17	Accumulated Depreciation (book methods)	(6,253,593)		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>Constr in Progress</u>	350,668		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,021,398	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,726,787	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 557,164	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	278,893		29
30	Accrued Salaries Payable	136,870		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>Due to Third Party Payers</u>	50,000		36
37	<u>Other Accrued expenses</u>	348,962		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,371,889	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	10,473,788		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Retirement Benefits and Other</u>	9,318		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 10,483,106	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 11,854,995	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,128,208)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,726,787	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,272,569)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,272,569)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	144,361	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)	\$ 144,361	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)	\$ (1,128,208)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Illini Restorative Care

0048264

Report Period Beginning: 07/01/2006

Ending: 06/30/2007

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	\$ 7,905,514	1
2	Discounts and Allowances for all Levels	(2,328,644)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,576,870	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,544,912	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,544,912	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	1,660	12
13	Barber and Beauty Care	41,207	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	21,626	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	1,428,717	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,493,210	23
D. Non-Operating Revenue			
24	Contributions	50,000	24
25	Interest and Other Investment Income***	14,670	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 64,670	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	299	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 299	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,679,961	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,196,091	31
32	Health Care	2,558,020	32
33	General Administration	2,142,047	33
B. Capital Expense			
34	Ownership	850,364	34
C. Ancillary Expense			
35	Special Cost Centers	309,761	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38	<u>Non-Allowable costs</u>	1,479,317	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,535,600	40
41	Income before Income Taxes (line 30 minus line 40)**	144,361	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 144,361	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 Restorative Care

0048264

Report Period Beginning: 07/01/2006

Ending:

06/30/2007

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	1,814	2,167	\$ 65,196	\$ 30.09	1
2	Assistant Director of Nursing	1,922	2,336	47,925	20.52	2
3	Registered Nurses	16,325	17,702	404,867	22.87	3
4	Licensed Practical Nurses	25,742	28,310	499,165	17.63	4
5	CNAs & Orderlies	68,665	75,400	809,614	10.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,377	4,819	55,823	11.58	8
9	Activity Director	1,922	2,249	32,134	14.29	9
10	Activity Assistants	3,064	3,582	36,502	10.19	10
11	Social Service Workers	3,550	4,151	66,082	15.92	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	9	9	164	18.22	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,599	1,896	96,996	51.16	20
21	Assistant Administrator	72	72	3,598	49.97	21
22	Other Administrative	5,200	6,007	83,738	13.94	22
23	Office Manager	4,596	5,278	125,470	23.77	23
24	Clerical	1,880	2,234	29,489	13.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	140,737	156,212	\$ 2,356,763 *	\$ 15.09	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 Restorative Care

0048264

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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		\$ 96,996	Workers' Compensation Insurance	\$ 42,869	IDPH License Fee	\$	
Other Administrative			148,023	Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes	178,070	Health Care Worker Background Check		
				Employee Health Insurance	304,013	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues Ill. Council Long Term Care	3,978	
				Pension	102,723	Dues Ill. Nsg Home Admin. Assoc.	100	
				Employee Assistance Program	3,457	Other Dues/Subscriptions	3,725	
				Long Term Disability	10,900			
				Life Insurance	4,749			
				Other Benefits	5,855	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
\$ 245,019				\$ 652,636			\$ 7,803	
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
Corporate Allocations			\$ 480,126			\$	Out-of-State Travel	\$
Telephone			33,227					
Insurance			42,515				In-State Travel	
Other Administrative			51,036				Education & Travel	5,271
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
\$ 606,904				\$			\$ 5,271	
C. Professional Services								
Vendor/Payee	Type		Amount					
Illini Hospital	Accounting Fees		\$ 500,708					
Mcgladrey Pullen LLC	Audit Fees		35,178					
Other	Bank/Legal Fees		13,605					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
\$ 549,491				\$			\$ 5,271	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Illini Restorative Care

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. See Attached
- (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 X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 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, 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. \$ No Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? Yes
- 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? _____
- 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? Y**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? _____
Firm Name: Mcglardery & Pullen LLC 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 \$5,000, 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.