

Facility Name & ID Number Illini Restorative Care

0048264 Report Period Beginning: 7/1/2007 Ending: 6/30/2008

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 N/A

	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>8,052</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>53</u>	Intermediate (ICF)	<u>53</u>	<u>19,398</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>45</u>	ICF/DD 16 or Less	<u>45</u>	<u>16,470</u>	6
7	<u>120</u>	TOTALS	<u>120</u>	<u>43,920</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>1,066</u>	<u>6,184</u>	<u>7,250</u>	8
9	SNF/PED					9
10	ICF	<u>6,697</u>	<u>11,189</u>		<u>17,886</u>	10
11	ICF/DD					11
12	SC		<u>14,809</u>		<u>14,809</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>6,697</u>	<u>27,064</u>	<u>6,184</u>	<u>39,945</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.95%

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

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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 08/12/1991 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 6,184

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/08 Fiscal Year: 6/30/08

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

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 7/1/2007 Ending: 6/30/2008

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			19,281	19,281		19,281	19,281			1
2	Food Purchase		641,470		641,470		641,470	291,725	933,195		2
3	Housekeeping		13,869	301,188	315,057		315,057	(127,968)	187,089		3
4	Laundry							178,470	178,470		4
5	Heat and Other Utilities										5
6	Maintenance		2,522	285,803	288,325		288,325	(46,558)	241,767		6
7	Other (specify):*							184,511	184,511		7
8	TOTAL General Services		657,861	606,272	1,264,133		1,264,133	480,180	1,744,313		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,969,559	26,257	136,392	2,132,208		2,132,208		2,132,208		10
10a	Therapy	205,852	453	83,703	290,008		290,008	(48,401)	241,607		10a
11	Activities	78,600	4,862	10,926	94,388		94,388		94,388		11
12	Social Services	66,029	203	1,800	68,032		68,032		68,032		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,320,040	31,775	232,821	2,584,636		2,584,636	(48,401)	2,536,235		16
	C. General Administration										
17	Administrative	260,898	7,477	647,820	916,195		916,195	48,966	965,161		17
18	Directors Fees										18
19	Professional Services			258,420	258,420		258,420		258,420		19
20	Dues, Fees, Subscriptions & Promotions			15,687	15,687		15,687	(7,897)	7,790		20
21	Clerical & General Office Expenses	51,672	1,021	2,930	55,623		55,623		55,623		21
22	Employee Benefits & Payroll Taxes			637,994	637,994		637,994	(2,629)	635,365		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,256	7,256		7,256		7,256		24
25	Other Admin. Staff Transportation			1,062	1,062		1,062		1,062		25
26	Insurance-Prop.Liab.Malpractice										26
27	Other (specify):*										27
28	TOTAL General Administration	312,570	8,498	1,571,169	1,892,237		1,892,237	38,440	1,930,677		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,632,610	698,134	2,410,262	5,741,006		5,741,006	470,219	6,211,225		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: 7/1/2007 Ending: 6/30/2008

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			304,282	304,282		304,282	1,435	305,717			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			544,314	544,314		544,314	(18,189)	526,125			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			848,596	848,596		848,596	(16,754)	831,842			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		312,635	14	312,649		312,649		312,649			39
40	Barber and Beauty Shops			26,529	26,529		26,529		26,529			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		312,635	26,543	339,178		339,178		339,178			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,632,610	1,010,769	3,285,401	6,928,780		6,928,780	453,465	7,382,245			45

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

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	(785)	3		5
6	Rented Facility Space	(48,401)	10a		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(10,562)	32		10
11	Discounts, Allowances, Rebates & Refunds	(183)	17		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(7,897)	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)	\$ (67,828)		\$	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)	519,858	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 519,858		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 452,030		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						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: 7/1/2007

Ending: 6/30/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Depreciation Correction for assets not yet FD	\$ 1,435	30	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	1,435		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Illini Restorative Care

0048264

Report Period Beginning:

7/1/2007

Ending:

6/30/2008

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	291,725	0	0	0	0	0	0	0	0	0	291,725	2
3	Housekeeping	(785)	(127,183)	0	0	0	0	0	0	0	0	0	(127,968)	3
4	Laundry	0	178,470	0	0	0	0	0	0	0	0	0	178,470	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	(46,558)	0	0	0	0	0	0	0	0	0	(46,558)	6
7	Other (specify):*	0	184,511	0	0	0	0	0	0	0	0	0	184,511	7
8	TOTAL General Services	(785)	480,965	0	480,180	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	(183)	49,149	0	0	0	0	0	0	0	0	0	48,966	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	(7,897)	0	0	0	0	0	0	0	0	0	0	(7,897)	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	(2,629)	0	0	0	0	0	0	0	0	0	(2,629)	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	(8,080)	46,520	0	38,440	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(57,266)	527,485	0	470,219	29								

STATE OF ILLINOIS

Facility Name & ID Number Illini Restorative Care

0048264

Report Period Beginning:

7/1/2007

Ending:

Summary B

6/30/2008

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	1,435	0	0	0	0	0	0	0	0	0	0	1,435	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,562)	(7,627)	0	0	0	0	0	0	0	0	0	(18,189)	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	(9,127)	(7,627)	0	(16,754)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(66,393)	519,858	0	453,465	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	\$ 637,994	Illini Hospital (B pt. 1 allocated cost)	100.00%	\$ 635,365	\$ (2,629)	1
2	V	17 Administrative & General	1,254,243	Illini Hospital (B pt. 1 allocated cost)	100.00%	1,303,392	49,149	2
3	V	4 Laundry		Illini Hospital (B pt. 1 allocated cost)	100.00%	178,470	178,470	3
4	V	3 Housekeeping	315,057	Illini Hospital (B pt. 1 allocated cost)	100.00%	187,874	(127,183)	4
5	V	2 Dietary	660,751	Illini Hospital (B pt. 1 allocated cost)	100.00%	952,476	291,725	5
6	V	7 Cafeteria		Illini Hospital (B pt. 1 allocated cost)	100.00%	184,511	184,511	6
7	V	30 CRC Buildings & Fixt -Depr	304,282	Illini Hospital (B pt. 1 allocated cost)	100.00%	304,282		7
8	V	32 CRC Bldngs & Fixt -Interest	544,314	Illini Hospital (B pt. 1 allocated cost)	100.00%	536,687	(7,627)	8
9	V	6 Plant Operations	288,325	Illini Hospital (B pt. 1 allocated cost)	100.00%	241,767	(46,558)	9
10	V	10 Nursing Administration	126,382	Illini Hospital (B pt. 1 allocated cost)	100.00%	126,382		10
11	V	12 Social Service	68,032	Illini Hospital (B pt. 1 allocated cost)	100.00%	68,032		11
12	V	11 Activity	94,388	Illini Hospital (B pt. 1 allocated cost)	100.00%	94,388		12
13	V							13
14	Total		\$ 4,293,768			\$ 4,813,626	\$ * 519,858	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:

7/1/2007

Ending:

6/30/2008

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			NOT APPLICABLE							3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Illini Restorative Care

0048264

Report Period Beginning:

7/1/2007

Ending: 7/30/2008

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Benefits	Salaries	21,105,853	3	\$ 6,218,914	\$ 2,156,310	\$ 635,364	1
2	17	Administrative & General	Accum. Cost	46,219,142	3	14,731,569	4,089,292	1,303,393	2
3	4	Linen	Linen Lbs	766,718	3	666,238	205,387	178,471	3
4	3	Housekeeping	Sq. Ft.	153,579	3	1,460,793	19,752	187,875	4
5	2	Dietary	Meals	301,749	3	2,204,730	130,360	952,476	5
6	7	Cafeteria	FTE's	818,347	3	992,259	152,172	184,511	6
7	30	CRC Buildings & Fixt -Depr	Sq. Ft.	51,538	3	304,282	51,538	304,282	7
8	32	CRC Bldgs & Fixt -Interest	Sq. Ft.	51,538	3	544,314	51,538	544,314	8
9	32	CRC Bld & Fxt-HO Int Inc ADJ	Sq. Ft.	259,350	3	(38,382)	51,538	(7,627)	9
10	6	Plant Operations	Sq. Ft.	49,295	3	268,737	44,348	241,768	10
11	10	Nursing Administration	Nsg Hrs	10,000	3	126,382	10,000	126,382	11
12	12	Social Service	IRC Discharges	1,000	3	68,032	1,000	68,032	12
13	11	Activity	Days	1,000	3	94,388	1,000	94,388	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					\$ 27,642,256	\$	\$ 4,813,629	25

Facility Name & ID Number

Illini Restorative Care

0048264

Report Period Beginning:

7/1/2007

Ending:

6/30/2008

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
		A. Directly Facility Related										
Long-Term												
1			X	Mortgage	Varies	6/28/06	\$ 11,000,000	\$ 10,685,813	7/2011	0.0690	\$ 544,314	1
2												2
3												3
4												4
5												5
Working Capital												
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 11,000,000	\$ 10,685,813			\$ 544,314	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	\$ 10,685,813			\$ 544,314	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 7,430 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

1. Real Estate Tax accrual used on 2007 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2008 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:					
2003	<u>Not Applicable</u>	8			
2004	_____	9			
2005	_____	10			
2006	_____	11			
2007	_____	12			
			FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2007	\$		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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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. <u>NOT APPLICABLE</u>	<u>NOT APPLICABLE</u>	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

7/1/2007 Ending:

6/30/2008

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:

7/1/2007

Ending:

6/30/2008

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	\$ 14,617	40	\$ 14,617	\$	\$ 252,135	4
5			2000		5,435,418	135,885	40	135,885		1,064,436	5
6											6
7											7
8											8
	Improvement Type**										
9	Electrical Feed		1991		1,209	61	20	61		1,041	9
10	Architect Fees		1991		89,731	2,243	40	2,243		38,697	10
11	Field Tests		1991		1,547	39	40	39		667	11
12	Time & Material Work		1991		17,753	444	40	444		7,656	12
13	Kitchen Plan		1991		1,025	26	40	26		442	13
14	Heating/Ventilation/Air Conditioning		1991		27,371	684	40	684		11,803	14
15	Pipe Recepticals		1991		7,746	310	25	310		5,344	15
16	Kitchen & Lounge		1991		40,623	1,016	40	1,016		17,519	16
17	Copper Wire		1991		3,981	199	20	199		3,434	17
18	Sewer Line		1991		18,770	938	20	938		16,189	18
19	Elevator Auto Ret. Sy		1991		1,042	52	20	52		899	19
20	Sheet Metal		1991		3,843	192	20	192		3,314	20
21	Wood Door Frames/Hardware		1991		53,541	2,677	20	2,677		46,179	21
22	Metal Windows		1991		13,134	657	20	657		11,328	22
23	Aluminum Entrance		1991		7,608	380	20	380		6,562	23
24	Ceramic Tile		1991		3,575	179	20	179		3,084	24
25	Pumbing/Sprinkler work		1991		211,741	10,587	20	10,587		182,626	25
26	Heating		1991		157,820	7,736	18	7,736		157,820	26
27	Air Conditioning		1991		133,565	6,548	18	6,548		133,565	27
28	Electrical		1991		128,975	6,449	20	6,449		111,241	28
29	Plumbing&Electrical Util		1991		44,800	2,240	20	2,240		38,640	29
30	Building		1991		88,055	2,201	40	2,201		37,974	30
31	Vinyl		1992		578	29	20	29		449	31
32	Handrails. IRC		1994		5,358	357	15	357		4,941	32
33	PT Utility Study		1995		142,758	9,517	15	9,517		126,103	33
34	Air Compressor for Chiller		1997		14,196	946	15	946		10,016	34
35	Tie In Piping Hot Water to IRC		1998		1,766	88	20	88		838	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:

7/1/2007

Ending:

6/30/2008

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

1	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	138	10	138	1,316	38
39	IRC Roof Hatches	2001	2,420	242	10	242	1,815	39
40	Door & Door Closers Exam Room	2001	1,523	102	15	102	762	40
41	Carpentry Patient Room Showers	2001	9,326	622	15	622	4,663	41
42	IRC Wall Hydrants	2002	1,354	135	10	135	880	42
43	IRC Wanderguard Relocation	2002	3,122	312	10	312	2,030	43
44	Medicare Rooms Wall Guards	2002	772	77	10	77	502	44
45	AHU Valve Control Upgrade	2002	3,328	333	10	333	2,163	45
46	IRC Cooling Unit Controls	2002	4,567	457	10	457	2,969	46
47	Sheltered Care Addition	2001	(196,204)	(4,905)	40	(4,905)	(34,336)	47
48	IRC Carpet Hallway	2002	10,072		5		10,072	48
49	Double Egress Door Replacement	2002	4,342	217	20	217	1,411	49
50	Scurity System	2003	6,267	627	10	627	3,447	50
51	IRC Loading Dock	2003	97,613	3,905	25	3,905	21,475	51
52	Architect Fees	2004	41,400	1,035	40	1,035	4,658	52
53	Blue Prints PT	2004	36	1	40	1	4	53
54	PT Construction	2004	80,180	2,004	40	2,004	9,020	54
55	PT Construction	2004	93,098	2,327	40	2,327	10,474	55
56	Wallcoverings	2004	490	98	5	98	441	56
57	Architect Fees IRC Laundry	2004	7,056	176	40	176	794	57
58	Blue Prints IRC Laundry	2004	122	3	40	3	14	58
59	Construction IRC Laundry	2004	24,446	611	40	611	2,750	59
60	Contact Services IRC Laundry	2004	60,362	1,509	40	1,509	6,791	60
61	RVS Architect Fees	2004	(1,655)	(41)	40	(41)	(186)	61
62	Blue Prints IRC Laundry	2004	(122)	(3)	40	(3)	(14)	62
63	Contact Services IRC Laundry	2004	(3,023)	(75)	40	(75)	(340)	63
64	Boiler Replacement Deaerator	2005	18,280	1,219	15	1,219	4,265	64
65	Air/Dirt Separator	2004	4,905	490	10	490	1,717	65
66	Roof	2005	51,860	5,186	10	5,186	12,965	66
67	Acuator Controls	2005	4,092	205	20	205	512	67
68	Valve Replacements	2006	12,432	622	20	622	1,554	68
69								69
70	TOTAL (lines 4 thru 69)		\$ 7,586,036	\$ 224,926		\$ 224,926	\$ 2,369,530	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:

7/1/2007

Ending:

6/30/2008

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	\$ 224,926		\$ 224,926	\$	\$ 2,369,530	1
2	Conduit & Wiring	2005	1,539	77	20	77		192	2
3	Construction	2005	199,131	19,913	10	19,913		49,783	3
4	Design Fees	2005	15,555	1,556	10	1,556		3,889	4
5	Heating & Cooling Valves	2005			15				5
6	Heating & Cooling Valves	2005			15				6
7	Design Fees	2006	1,601	160	10	160		400	7
8	Hollow Metal Doors	2006	10,987	549	20	549		1,373	8
9	Electric Switch Gear	2006	3,719	248	15	248		372	9
10	Cabinets/Casework	1991	23,231	1,162	20	1,162		20,037	10
11	Elevators	1991	13,665	683	20	683		11,786	11
12	Nurse Call System	1992	2,043		15			2,043	12
13	Handrail and Door	1992	1,470		15			1,470	13
14	Alarm System	1992	587	17	15	17		587	14
15	Remodel IRC Nurse Station	1997	3,340	223	15	223		2,486	15
16	Cabinets/Storage Util Room	1997	4,103	274	15	274		3,054	16
17	Double Egress Wood Doors	1998	2,756	184	15	184		1,868	17
18	Wood Replace Doors IRC	1999	1,308	87	15	87		741	18
19	4" Sprinkler	2000	18,675	747	25	747		6,349	19
20	Data Voice Wiring	2000	31,453	3,145	10	3,145		23,590	20
21	Door Alarm Sheltered Care	2000	2,211	221	10	221		1,658	21
22	Analog Message-Sheltered Care	2000	2,693	269	10	269		2,020	22
23	Phone System Shelterd Care	2000	25,643	2,564	10	2,564		19,232	23
24	Air Cind./Handling unit	2001	2,187	219	10	219		1,640	24
25	Nurse Call System SC	2001	6,498	650	10	650		4,873	25
26	Kitchen Cabinets SC	2001	4,077	272	15	272		2,038	26
27	IRC Boiler Stack	2001	14,750	738	20	738		5,531	27
28	PA System IRC Dining Room	2001	1,682	168	10	168		1,261	28
29	Door Wooden IRC	2001	1,465	98	15	98		635	29
30	IRC Bedpan Washers	2002	2,923	195	15	195		1,266	30
31	Switchboard Cable IRC	2002	4,831	483	10	483		3,140	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,990,159	\$ 259,828		\$ 259,828	\$	\$ 2,542,844	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:

7/1/2007

Ending:

6/30/2008

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		\$ 7,990,159	\$ 259,828		\$ 259,828	\$	\$ 2,542,844	1
2	Boiler Fail Over Controls	2002	1,905	191	10	191		1,238	2
3	Bronze Circulating Pump	2003	1,937	194	10	194		1,065	3
4	Air Conditioning Unit	2003	2,755	394	7	394		2,164	4
5	IRC Door Alarm	2003	5,792	579	10	579		3,186	5
6	Canopy	2003	2,275	152	15	152		683	6
7	Air Handling IRC Laundry	2004	19,065	953	20	953		4,290	7
8	RVS Air Handling Cap	2004	(19,065)	(953)	20	(953)		(4,290)	8
9	Drapes (Fabric and Sheer)	2006	2,304	461	5	461		1,152	9
10	Repair Sidewalk	1994	1,874	125	15	125		1,791	10
11	Sidewalk	1995	710	47	15	47		639	11
12	Parking Lot Repairs	1996	3,561		8			3,561	12
13	Landscaping IRC	1998	2,176	218	10	218		2,067	13
14	Concrete Replacement	2001	2,239	149	15	149		1,120	14
15	Asphalt Parking Lot NW Area	2002	44,394	5,549	8	5,549		36,070	15
16	Parking Lot Lights NW Area	2002	9,535	953	10	953		6,198	16
17	Landscaping	2005	2,511	251	10	251		628	17
18									18
19	IRC Boiler Tank	2008	3,373	169	10	169		169	19
20	Repair Sidewalk, LSC Survey	2008	2,257	75	15	75		75	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)		\$ 8,079,757	\$ 269,335		\$ 269,335	\$	\$ 2,604,650	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: 7/1/2007 Ending: 6/30/2008

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	\$ 453,497	\$ 36,251	\$ 36,251	\$	14	\$ 686,961	71
72	Current Year Purchases	2,615	131	131		10	131	72
73	Fully Depreciated Assets	423,706						73
74								74
75	TOTALS	\$ 879,818	\$ 36,382	\$ 36,382	\$		\$ 687,092	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)	\$ 9,017,298	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 305,717	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 305,717	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)	\$ 3,291,742	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: N/A

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:	<u>N/A</u>			\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	TOTAL				\$ _____			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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.	<u>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</u>	\$ _____

* 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			5,088			5,088	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			78,573			78,573	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				197,120		197,120	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$ 83,661	\$ 197,120		\$ 280,781	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: 7/1/2007

Ending:

6/30/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2008

(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	\$ 1,304,211	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,086,213		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,217		6
7	Other Prepaid Expenses	9,804		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from Affiliates</u>	193,973		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,625,418	\$	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	12,234,563		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,632,038		16
17	Accumulated Depreciation (book methods)	(6,542,204)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>C-I-P</u>	577,532		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,959,652	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,585,070	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 87,766	\$	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	252,489		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>Affiliate and Third party Payables</u>	533,238		36
37	<u>Other Accrued Exp</u>	50,064		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,202,450	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	10,406,920		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 10,406,920	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 11,609,370	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,024,300)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,585,070	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,128,208)	1
2	Restatements (describe):		2
3	Reconciling adj to PY	(11,893)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,140,101)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	400,725	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)	\$ 400,725	17
B. Transfers (Itemize):			
18	System Preliminary Undistributed Income / Loss	(284,924)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (284,924)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,024,300)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Illini Restorative Care

0048264

Report Period Beginning: 7/1/2007

Ending: 6/30/2008

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	\$ 10,684,740	1
2	Discounts and Allowances for all Levels	(2,127,210)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,557,530	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	28,542	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	785	15
16	Rental of Facility Space	48,401	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	(180)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 77,548	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	10,562	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,562	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Other Misc CS services</u>	69,729	28
28a	<u>Other Misc Adm</u>	183	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 69,912	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,715,552	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,264,133	31
32	Health Care	2,584,636	32
33	General Administration	1,892,237	33
B. Capital Expense			
34	Ownership	848,596	34
C. Ancillary Expense			
35	Special Cost Centers	339,178	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37	<u>Non-Allowable CS and Other Expenses</u>	1,386,047	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,314,827	40
41	Income before Income Taxes (line 30 minus line 40)**	400,725	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 400,725	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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: 7/1/2007

Ending:

6/30/2008

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	1,948	2,116	\$ 68,124	\$ 32.19	1
2	Assistant Director of Nursing	1,780	2,026	52,966	26.14	2
3	Registered Nurses	14,698	16,220	388,688	23.96	3
4	Licensed Practical Nurses	30,529	33,711	579,390	17.19	4
5	CNAs & Orderlies	65,505	71,558	826,272	11.55	5
6	CNA Trainees					6
7	Licensed Therapist	4,765	4,778	129,686	27.14	7
8	Rehab/Therapy Aides	7,193	7,652	124,601	16.28	8
9	Activity Director	1,779	2,173	33,029	15.20	9
10	Activity Assistants	4,423	4,931	47,492	9.63	10
11	Social Service Workers	1,816	2,120	43,536	20.54	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	1,736	1,926	100,611	52.24	20
21	Assistant Administrator	1,648	1,928	57,259	29.70	21
22	Other Administrative	5,173	5,840	79,982	13.70	22
23	Office Manager	3,298	3,728	60,221	16.15	23
24	Clerical	2,988	3,104	40,753	13.13	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)	149,279	163,811	\$ 2,632,610 *	\$ 16.07	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

Report Period Beginning: 7/1/2007

Ending: 6/30/2008

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	0	\$ 105,124	Workers' Compensation Insurance	\$ 49,610	IDPH License Fee	\$		
Other Administrative	Bus offc		155,774	Unemployment Compensation Insurance		Advertising: Employee Recruitment			
				FICA Taxes	191,289	Health Care Worker Background Check			
				Employee Health Insurance	273,194	(Indicate # of checks performed)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Dues Ill. Council Long Term Care	4,844		
				Pension	103,089	Dues Ill. Nsg Home Admin. Assoc.	100		
				Employee Assistance Program	3,642	Other Dues/Subscriptions	2,846		
				Long Term Disability	11,515	Adv and Promotions	7,897		
				Life Insurance	4,873				
				Other Benefits	782	Less: Public Relations Expense	()		
				Hospital OH Allocation Adj	(2,629)	Non-allowable advertising	(7,897)		
						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)		
\$ 260,898				\$ 635,365			\$ 7,790		
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			\$ 516,484			\$	Out-of-State Travel	\$	
Telephone			33,218						
Insurance			31,061				In-State Travel		
Other Administrative			67,057				Education & Travel	7,256	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense		
\$ 647,820				\$			Entertainment Expense		()
C. Professional Services									
Vendor/Payee	Type		Amount						
Illini Hospital	Accounting Fees		255,910				(agree to Sch. V, line 24, col. 8)		
McGladrey & Pullen LLC	Audit Fees		1,283				TOTAL		
Other	Bank/Legal Fees		1,227				\$ 7,256		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)									
\$ 258,420									

* 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. See Sch XIX
- (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. \$ 8,369 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. \$ None Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey & Pullen 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.