

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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.

<p>I. IDPH License ID Number: <u>0048264</u></p> <p>Facility Name: <u>Illini Restorative Care</u></p> <p>Address: <u>1455 Hospital Road</u> <u>Silvis</u> <u>61282</u> Number City Zip Code</p> <p>County: <u>Rock Island</u></p> <p>Telephone Number: <u>(309) 792-7614</u> Fax # <u>(309) 792-7611</u></p> <p>HFS ID Number: <u>36-3616314001</u></p> <p>Date of Initial License for Current Owners: <u>08/12/1991</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<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 _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2008</u> to <u>06/30/2009</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Mark G. Rogers</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>VP, Finance/CFO</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) (____) _____</td> <td>Fax # (____) _____</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Mark G. Rogers</u>			(Title) <u>VP, Finance/CFO</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) (____) _____	Fax # (____) _____
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<p>In the event there are further questions about this report, please contact: Name: <u>Diana Bollaert</u> Telephone Number: <u>(563) 421-1996</u> Email Address: _____</p>	<p>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</p>																																									

Facility Name & ID Number Illini Restorative Care

0048264 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	0	360	6,727	7,087	8	
9	SNF/PED					9	
10	ICF	6,764	10,540	0	17,304	10	
11	ICF/DD					11	
12	SC	0	14,197	0	14,197	12	
13	DD 16 OR LESS					13	
14	TOTALS	6,764	25,097	6,727	38,588	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.10%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 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 6,727

Medicare Intermediary Wisconsin Physician Service

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/2009 Fiscal Year: 06/30/2009

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

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

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			965	965	965		965			1
2	Food Purchase		667,996		667,996	667,996	308,639	976,635			2
3	Housekeeping		15,771	195,944	211,715	211,715	(33,312)	178,403			3
4	Laundry						124,786	124,786			4
5	Heat and Other Utilities										5
6	Maintenance		3,515	298,906	302,421	302,421	(56,030)	246,391			6
7	Other (specify):*						188,980	188,980			7
8	TOTAL General Services		687,282	495,815	1,183,097	1,183,097	533,063	1,716,160			8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	2,034,557	26,242	264,909	2,325,708	2,325,708		2,325,708			10
10a	Therapy	258,921	1,123	36,808	296,852	296,852	(48,402)	248,450			10a
11	Activities	75,493	4,257	9,454	89,204	89,204		89,204			11
12	Social Services	67,033	338	1,800	69,171	69,171		69,171			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,436,004	31,960	312,971	2,780,935	2,780,935	(48,402)	2,732,533			16
	C. General Administration										
17	Administrative	257,616	6,994	997,459	1,262,069	1,262,069	(501,783)	760,286			17
18	Directors Fees										18
19	Professional Services			5,053	5,053	5,053		5,053			19
20	Dues, Fees, Subscriptions & Promotions			11,067	11,067	11,067	(355)	10,712			20
21	Clerical & General Office Expenses	46,760	1,593		48,353	48,353		48,353			21
22	Employee Benefits & Payroll Taxes			623,104	623,104	623,104	(243,573)	379,531			22
23	Inservice Training & Education										23
24	Travel and Seminar			6,433	6,433	6,433		6,433			24
25	Other Admin. Staff Transportation			520	520	520		520			25
26	Insurance-Prop.Liab.Malpractice										26
27	Other (specify):*										27
28	TOTAL General Administration	304,376	8,587	1,643,636	1,956,599	1,956,599	(745,711)	1,210,888			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,740,380	727,829	2,452,422	5,920,631	5,920,631	(261,050)	5,659,581			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:

07/01/2008

Ending:

06/30/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			322,218	322,218		322,218	494,333	816,551			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			528,169	528,169		528,169	(144,035)	384,134			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			850,387	850,387		850,387	350,298	1,200,685			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		351,402	169	351,571		351,571		351,571			39
40	Barber and Beauty Shops		106	25,603	25,709		25,709		25,709			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		351,508	25,772	377,280		377,280		377,280			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,740,380	1,079,337	3,328,581	7,148,298		7,148,298	89,248	7,237,546			45

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

Illini Restorative Care

ID# 0048264

Report Period Beginning: 07/01/2008

Ending: 06/30/2009

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:

07/01/2008

Ending:

06/30/2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	308,639	0	0	0	0	0	0	0	0	0	308,639	2
3	Housekeeping	(1,040)	(32,272)	0	0	0	0	0	0	0	0	0	(33,312)	3
4	Laundry	0	124,786	0	0	0	0	0	0	0	0	0	124,786	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	(56,030)	0	0	0	0	0	0	0	0	0	(56,030)	6
7	Other (specify):*	0	188,980	0	0	0	0	0	0	0	0	0	188,980	7
8	TOTAL General Services	(1,040)	534,103	0	533,063	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	(48,402)	0	0	0	0	0	0	0	0	0	0	(48,402)	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	(48,402)	0	0	0	0	0	0	0	0	0	0	(48,402)	16
	C. General Administration													
17	Administrative	(448)	(501,335)	0	0	0	0	0	0	0	0	0	(501,783)	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	(355)	0	0	0	0	0	0	0	0	0	0	(355)	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	(243,573)	0	0	0	0	0	0	0	0	0	(243,573)	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	(803)	(744,908)	0	(745,711)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(50,245)	(210,805)	0	(261,050)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Illini Restorative Care# 0048264

Report Period Beginning:

07/01/2008 Ending:

06/30/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	494,333	0	0	0	0	0	0	0	0	0	494,333	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,777)	(135,258)	0	0	0	0	0	0	0	0	0	(144,035)	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	(8,777)	359,075	0	350,298	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(59,022)	148,270	0	0	0	0	0	0	0	0	0	89,248	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
<u>Illini Nursing Home</u>	<u>100%</u>	<u>Illini Restorative Care Center</u>	<u>Silvis</u>	<u>Illini Hospital</u>	<u>Silvis</u>	<u>Hospital</u>
				<u>Crosstown Square</u>	<u>Silvis</u>	<u>Senior Apts.</u>
				<u>Genesis Health Sys</u>	<u>Davenport</u>	<u>Home Office</u>

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	<u>2 Dietary</u>	\$ <u>668,961</u>	<u>Illini Hospital (B Pt I Allocated Cost)</u>	<u>100.00%</u>	\$ <u>977,600</u>	\$ <u>308,639</u>	1
2	V	<u>3 Housekeeping</u>	<u>211,715</u>	<u>Illini Hospital (B Pt I Allocated Cost)</u>	<u>100.00%</u>	<u>179,443</u>	<u>(32,272)</u>	2
3	V	<u>4 Laundry</u>		<u>Illini Hospital (B Pt I Allocated Cost)</u>	<u>100.00%</u>	<u>124,786</u>	<u>124,786</u>	3
4	V	<u>6 Plant Op/Maintenance</u>	<u>302,421</u>	<u>Illini Hospital (B Pt I Allocated Cost)</u>	<u>100.00%</u>	<u>246,391</u>	<u>(56,030)</u>	4
5	V	<u>7 Cafeteria</u>		<u>Illini Hospital (B Pt I Allocated Cost)</u>	<u>100.00%</u>	<u>188,980</u>	<u>188,980</u>	5
6	V	<u>10 Nursing Administration</u>	<u>206,299</u>	<u>Illini Hospital (B Pt I Allocated Cost)</u>	<u>100.00%</u>	<u>206,299</u>		6
7	V	<u>11 Activity</u>	<u>89,204</u>	<u>Illini Hospital (B Pt I Allocated Cost)</u>	<u>100.00%</u>	<u>89,204</u>		7
8	V	<u>12 Social Service</u>	<u>69,171</u>	<u>Illini Hospital (B Pt I Allocated Cost)</u>	<u>100.00%</u>	<u>69,171</u>		8
9	V	<u>17 Administrative & General</u>	<u>1,333,495</u>	<u>Illini Hospital (B Pt I Allocated Cost)</u>	<u>100.00%</u>	<u>832,160</u>	<u>(501,335)</u>	9
10	V	<u>22 Employee Benefits</u>	<u>623,104</u>	<u>Illini Hospital (B Pt I Allocated Cost)</u>	<u>100.00%</u>	<u>379,531</u>	<u>(243,573)</u>	10
11	V	<u>30 CRC Bldgs & Fixt-Depr</u>	<u>322,218</u>	<u>Illini Hospital (B Pt I Allocated Cost)</u>	<u>100.00%</u>	<u>816,551</u>	<u>494,333</u>	11
12	V	<u>32 CRC Bldgs & Fixt-Interest</u>	<u>528,169</u>	<u>Illini Hospital (B Pt I Allocated Cost)</u>	<u>100.00%</u>	<u>392,911</u>	<u>(135,258)</u>	12
13	V							13
14	Total		\$ <u>4,354,757</u>			\$ <u>4,503,027</u>	\$ * <u>148,270</u>	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:

07/01/2008

Ending:

06/30/2009

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:

07/01/2008

Ending: 6/30/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	2	Dietary	Meals	301,749	3	\$ 2,262,887	\$ 130,360	\$ 977,600	1
2	3	Housekeeping	Square Feet	153,579	3	1,395,230	19,752	179,442	2
3	4	Laundry	Linen Pounds	766,718	3	465,830	205,387	124,786	3
4	6	Plant Op/Maintenance	Square Feet	49,295	3	273,876	44,348	246,391	4
5	7	Cafeteria	FTEs	818,347	3	1,016,349	152,172	188,991	5
6	10	Nursing Administration	Nursing Hours	10,000	3	206,299	10,000	206,299	6
7	11	Activity	Days	1,000	3	89,204	1,000	89,204	7
8	12	Social Service	IRC Discharges	1,000	3	69,171	1,000	69,171	8
9	17	Administrative & General	Accum. Cost	199,779,143	3	14,277,477	11,644,082	832,160	9
10	22	Employee Benefits	Salaries	22,734,246	3	3,887,842	2,219,312	379,530	10
11	30	CRC Bldgs & Fixt-Depr	Square Feet	207,812	3	265,884	638,207	816,551	11
12	32	CRC Bldgs & Fixt-Interest	Square Feet	51,538	3	456,611	44,348	392,910	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 24,666,660	\$	\$ 4,503,035	25

Facility Name & ID Number

Illini Restorative Care

0048264

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Quad City Bank & Trust		X	Mortgage	\$85,370.00	6/28/06	\$ 11,000,000	\$ 10,172,957	7/5/11	0.0690	\$ 528,169	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$85,370.00		\$ 11,000,000	\$ 10,172,957			\$ 528,169	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	\$ 10,172,957			\$ 528,169	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 8,280 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.)

Facility Name & ID Number Illini Restorative Care

0048264

Report Period Beginning:

07/01/2008 Ending: 06/30/2009

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	Door and Door Closers Exam Rm	2001	\$ 1,524	\$ 102	15	\$ 102	\$	\$ 864	37
38	Carpentry Patient Room Showers	2001	9,326	622	15	622		5,285	38
39	IRC Wall Hydrants	2002	1,354	135	10	135		1,016	39
40	IRC Wanderguard Relocation	2002	3,122	312	10	312		2,342	40
41	Medicare Rooms Wall Guards	2002	772	77	10	77		579	41
42	Ahu Valve Control Upgrade	2002	3,328	333	10	333		2,496	42
43	IRC Cooling Unit Controls	2002	4,567	457	10	457		3,425	43
44	Sheltered Care Addition	2001	(196,204)	(4,905)	40	(4,905)		(39,241)	44
45	Double Egress Door Replacement	2002	4,342	217	20	217		1,628	45
46	Security System	2003	6,267	627	10	627		4,074	46
47	IRC Loading Dock	2003	97,613	3,905	25	3,905		25,379	47
48	Architect Fees	2004	41,400	1,035	40	1,035		5,693	48
49	Blue Prints PT	2004	36	1	40	1		5	49
50	PT Construction	2004	80,180	2,005	40	2,005		11,025	50
51	PT Construction	2004	93,088	2,327	40	2,327		12,801	51
52	Wallcoverings	2004	490	49	5	49		490	52
53	Architect Fees IRC Laundry	2004	7,056	176	40	176		970	53
54	Blue Prints IRC Laundry	2004	122	3	40	3		17	54
55	Construction IRC Laundry	2004	24,446	611	40	611		3,361	55
56	Contact Services IRC Laundry	2004	60,362	1,509	40	1,509		8,300	56
57	Rvs Arch Fees Already Cap	2004	(1,655)	(41)	40	(41)		(228)	57
58	Blue Prints IRC Laundry Rvs	2004	(122)	(3)	40	(3)		(17)	58
59	Contract Serv IRC Laundry Rvs	2004	(3,023)	(76)	40	(76)		(416)	59
60	Boiler Replacement Deaerator	2005	24,668	1,774	15	1,774		6,039	60
61	Air/Dirt Separator	2004	4,905	491	10	491		2,207	61
62	Roof	2005	51,860	5,186	10	5,186		18,151	62
63	Acuator Controls	2005	4,092	205	20	205		716	63
64	Valve Replacements	2006	12,432	622	20	622		2,176	64
65	Conduit & Wiring	2005	1,539	77	20	77		269	65
66	Construction	2005	199,131	19,913	10	19,913		69,696	66
67	Design Fees	2005	15,555	1,556	10	1,556		5,444	67
68	Design Fees	2006	1,601	160	10	160		560	68
69	Hollow Metal Doors	2006	10,987	549	20	549		1,923	69
70	TOTAL (lines 4 thru 69)		\$ 7,519,771	\$ 233,336		\$ 233,336	\$	\$ 2,357,044	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:

07/01/2008 Ending:

06/30/2009

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	220,902	1993 & 1999	\$ 33,442	1
2					2
3	TOTALS	220,902		\$ 33,442	3

Facility Name & ID Number Illini Restorative Care

0048264

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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	\$	\$ 266,752	4
5		2000		5,435,418	135,885	40	135,885		1,200,322	5
6										6
7										7
8										8
	Improvement Type**									
9	Sign Electrical Feed	1991		1,209	61	20	61		1,102	9
10	Legal & Professional	1991		89,731	2,243	40	2,243		40,940	10
11	Field Tests	1991		1,547	39	40	39		706	11
12	Time & Material Work	1991		17,753	444	40	444		8,100	12
13	Kitchen Plan	1991		1,025	26	40	26		468	13
14	Heating/Ventilation/Air Conditioning	1991		27,371	684	40	684		12,488	14
15	Pipe Recepticals, Ect	1991		7,746	310	25	310		5,654	15
16	Kitchen & Lounge	1991		40,623	1,016	40	1,016		18,534	16
17	Copper Wire	1991		3,981	199	20	199		3,633	17
18	Sewer Lines & Overbed	1991		18,770	939	20	939		17,128	18
19	Elevator Auto Ret Sy	1991		1,042	52	20	52		951	19
20	Sheet Metal	1991		3,843	192	20	192		3,506	20
21	Wood Doors & Frames, Hardware	1991		53,541	2,677	20	2,677		48,856	21
22	Metal Windows	1991		13,134	657	20	657		11,985	22
23	Alum Entrances & Storefront	1991		7,608	380	20	380		6,942	23
24	Ceramic Tile	1991		3,575	179	20	179		3,262	24
25	Plumbing, Sprinkler Work	1991		211,741	10,587	20	10,587		193,213	25
26	Electrical	1991		128,975	6,449	20	6,449		117,690	26
27	Plumbing & Electrical Util	1991		44,800	2,240	20	2,240		40,880	27
28	Building	1991		88,055	2,201	40	2,201		40,175	28
29	Vinyl	1992		578	29	20	29		478	29
30	Handrails - IRC	1994		5,358	357	15	357		5,298	30
31	P.T. Utility Study	1995		142,758	9,517	15	9,517		135,620	31
32	Air Compressor for Chillr	1997		14,196	946	15	946		10,963	32
33	Tie-In Piping Hot Water to IRC	1998		1,766	88	20	88		927	33
34	VPI Base & Ceramic Tile	1999		1,385	69	10	69		1,385	34
35	IRC Roof Hatches	2001		2,420	242	10	242		2,057	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:

07/01/2008 Ending: 06/30/2009

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		\$ 7,519,771	\$ 233,336		\$ 233,336	\$	\$ 2,357,044	1
2	Replace Corridor Doors	2009	15,509	517	15	517		517	2
3	Electric Switch Gear	2006	3,719	248	15	248		620	3
4	IRC Boiler Tank	2008	3,373	337	10	337		506	4
5	IRC Boiler Replacement	2008	99,083	2,914	17	2,914		2,914	5
6	Replace Nurse Call System	2008	60,202	3,010	10	3,010		3,010	6
7	Door Hold - Magnetic	2008	1,404	70	10	70		70	7
8	Fire Damper Doors LSC Survey	2008	7,877	197	20	197		197	8
9	Nurse Call System	2008	54,966	2,748	10	2,748		2,748	9
10	Air Conditioning/Cooling	2008	4,050	405	5	405		405	10
11	Boiler Replacement	2008	432,708	10,818	20	10,818		10,818	11
12	Magnetic Door Holder	2009	1,334	67	10	67		67	12
13	Replace Fire Alarm Panel	2009	62,446	3,122	10	3,122		3,122	13
14	Cabinets, Casework	1991	23,231	1,162	20	1,162		21,198	14
15	Elevators	1991	13,665	683	20	683		12,470	15
16	Remodel IRC Nurse Station	1997	3,340	223	15	223		2,709	16
17	Cabinets/Storage - Util Rm	1997	4,103	274	15	274		3,328	17
18	Double Egress Wood Doors	1998	2,756	184	15	184		2,051	18
19	Wood Replace Doors - IRC 4 Rooms	1999	1,308	87	15	87		828	19
20	4 Inch Sprinkler	2000	18,675	747	25	747		7,096	20
21	Data Voice Wiring-SC	2000	31,453	3,145	10	3,145		26,735	21
22	Door Alarm-Sheltered Care	2000	2,211	221	10	221		1,879	22
23	Analog Message-Sheltered Care	2000	2,693	269	10	269		2,289	23
24	Phone System-Sheltered Care	2000	25,643	2,564	10	2,564		21,796	24
25	Air Cond/Handling Unit	2001	2,187	219	10	219		1,859	25
26	Nurse Call System-SC	2001	6,498	650	10	650		5,523	26
27	Kitchen Cabinets-SC	2001	4,077	272	15	272		2,310	27
28	IRC Boiler Stack	2001	14,750	738	20	738		6,269	28
29	PA System IRC Dining Room	2001	1,682	168	10	168		1,430	29
30	Door Wooden IRC	2001	1,465	98	15	98		733	30
31	IRC Bedpan Washers	2002	2,923	195	15	195		1,461	31
32	Switchboard Cable IRC	2002	4,831	483	10	483		3,623	32
33	Boiler Fair Over Controls	2002	1,905	191	10	191		1,429	33
34	TOTAL (lines 1 thru 33)		\$ 8,435,838	\$ 270,362		\$ 270,362	\$	\$ 2,509,054	34

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

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		\$ 8,435,838	\$ 270,362		\$ 270,362	\$	\$ 2,509,054	1
2	Bronze Circulating Pump	2003	1,937	194	10	194		1,259	2
3	Air Conditioning Unit	2003	2,755	394	7	394		2,558	3
4	IRC Door Alarm	2003	5,792	579	10	579		3,765	4
5	Canopy	2003	2,275	152	15	152		834	5
6	Air Handling IRC Laundry	2004	19,065	953	20	953		5,243	6
7	Rvs Air Handling Cap FY03	2004	(19,065)	(953)	20	(953)		(5,243)	7
8	Drapes (Fabric & Sheer)	2006	2,304	461	5	461		1,612	8
9	Repair Sidewalk	1994	1,874	83	15	83		1,874	9
10	Sidewalk	1995	710	47	15	47		686	10
11	Landscaping-IRC	1998	2,176	109	10	109		2,176	11
12	Concrete Replacement	2001	2,239	147	15	147		1,269	12
13	Asphalt Parking Lot-NW Area	2002	44,394	5,549	8	5,549		41,620	13
14	Parking Lot Lights NW Area	2002	9,535	953	10	953		7,151	14
15	Landscaping	2005	2,511	251	10	251		879	15
16	Repair Sidewalk LSC Survey	2008	2,257	150	15	150		226	16
17	Replace Asphalt Entry Drive	2008	23,800	793	15	793		793	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)		\$ 8,540,397	\$ 280,224		\$ 280,224	\$	\$ 2,575,756	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 463,381	\$ 34,640	\$ 34,640	\$	14	\$ 655,632	71
72	Current Year Purchases	62,702	7,345	7,345		10	7,345	72
73	Fully Depreciated Assets	416,437						73
74								74
75	TOTALS	\$ 942,520	\$ 41,985	\$ 41,985	\$		\$ 662,977	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)	\$ 9,516,359	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 322,209	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 322,209	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)	\$ 3,238,733	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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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	\$		\$ 30,990	\$		\$ 30,990	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			5,156			5,156	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				228,558		228,558	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			\$		\$ 36,146	\$ 228,558		\$ 264,704	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: 07/01/2008Ending: 06/30/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2009

(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	\$ 1,675,935	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>403,497</u>)	888,244		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,398		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due From Affiliates</u>	31,377		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,604,954	\$	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	13,320,711		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,717,983		16
17	Accumulated Depreciation (book methods)	(7,357,112)		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>CIP</u>	27,991		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,767,296	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,372,250	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 152,535	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	322,840		29
30	Accrued Salaries Payable	230,582		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,572		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>	221,144		36
37	<u>Other Accrued Expenses</u>	98,896		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,027,569	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	9,850,117		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Other-Accrued Pension Costs</u>	2,150		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 9,852,267	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 10,879,836	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (507,586)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,372,250	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,024,300)	1
2	Restatements (describe):		2
3	Reconciling adj to PY	1,772,297	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 747,997	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(6,948)	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)	\$ (6,948)	17
	B. Transfers (Itemize):		
18	System Undistributed Earnings	(233,463)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (233,463)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 507,586	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Illini Restorative Care# 0048264Report Period Beginning: 07/01/2008Ending: 06/30/2009

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	\$ 10,624,400	1
2	Discounts and Allowances for all Levels	(2,167,415)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,456,985	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	40,216	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	1,040	15
16	Rental of Facility Space	48,402	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		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 89,658	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	8,776	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,776	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Misc Admin	7,202	28
28a	Rental Income-Related Party	48,402	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 55,604	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,611,023	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,183,097	31
32	Health Care	2,780,935	32
33	General Administration	1,956,599	33
B. Capital Expense			
34	Ownership	850,387	34
C. Ancillary Expense			
35	Special Cost Centers	377,280	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37	Non-Allowable CS and Other Expenses	1,235,767	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,384,065	40
41	Income before Income Taxes (line 30 minus line 40)**	226,958	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 226,958	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: 07/01/2008

Ending: 06/30/2009

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	867	1,269	\$ 74,348	\$ 58.59	1
2	Assistant Director of Nursing	1,598	1,800	46,760	25.98	2
3	Registered Nurses	15,708	23,784	372,427	15.66	3
4	Licensed Practical Nurses	42,138	51,368	598,299	11.65	4
5	CNAs & Orderlies	84,149	116,448	859,479	7.38	5
6	CNA Trainees					6
7	Licensed Therapist	6,561	6,649	171,791	25.84	7
8	Rehab/Therapy Aides	9,495	10,419	140,090	13.45	8
9	Activity Director	1,853	2,541	32,375	12.74	9
10	Activity Assistants	3,958	4,865	43,074	8.85	10
11	Social Service Workers	1,823	2,114	43,089	20.38	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	350	572	81,070	141.73	20
21	Assistant Administrator	1,795	1,989	68,431	34.40	21
22	Other Administrative	5,310	6,464	86,666	13.41	22
23	Office Manager	4,049	4,611	69,840	15.15	23
24	Clerical	3,768	4,163	49,720	11.94	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)	183,422	239,056	\$ 2,737,459 *	\$ 11.45	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

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	\$ 83,992	Workers' Compensation Insurance	\$ 30,783	IDPH License Fee	\$	
Other Administrative	Business Ofc	0	173,624	Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes	199,923	Health Care Worker Background Check		
				Employee Health Insurance	210,377	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues Ill. Council Long Term Care	6,440	
				Pension	107,307	Dues Ill. Nrsg Home Admin. Assoc.	100	
				Employee Assistance Program	4,175	Other Dues/Subscriptions	4,172	
				Long Term Disability	10,945	Advertising and Promotion	355	
				Life Insurance	4,587			
				Other Benefits	55,006	Less: Public Relations Expense	()	
				Hospital OH Allocation Adj	(243,573)	Non-allowable advertising	(355)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 257,616	TOTAL (agree to Schedule V, line 22, col.8)	\$ 379,530	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,712	
(List each licensed administrator separately.)								
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			\$ 338,873			\$	Out-of-State Travel	\$
Telephone			33,434					
Insurance			33,794				In-State Travel	
Other Administrative			591,358				Education & Travel	6,433
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 997,459				Seminar Expense	
(Attach a copy of any management service agreement)								
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount				()	
FR R Consulting	Consulting Fees		\$ 3,119				TOTAL (agree to Sch. V, line 24, col. 8)	
Conceptual Design	Consulting Fees		1,930				\$ 6,433	
Other	Bank/Legal Fees		4					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 5,053					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Illini Restorative Care# 0048264Report Period Beginning: 07/01/2008 Ending: 06/30/2009**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 Schedule 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. \$ 4,125 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. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation 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: RSM McGladrey & Pullen
- (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.