

Facility Name & ID Number Illini Restorative Care

0048264 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	83	Skilled (SNF)	83	30,295	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	37	Sheltered Care (SC)	37	13,505	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	5,050	10,876	11,545	27,471	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		10,693		10,693	12
13	DD 16 OR LESS					13
14	TOTALS	5,050	21,569	11,545	38,164	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.13%

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 83 and days of care provided 27,471

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/2014 Fiscal Year: 06/30/2014

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

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			508	508		508		508		1
2	Food Purchase		700,130		700,130		700,130	202,907	903,037		2
3	Housekeeping	127,273	13,196	65,360	205,829		205,829		205,829		3
4	Laundry							104,858	104,858		4
5	Heat and Other Utilities			41,060	41,060		41,060		41,060		5
6	Maintenance	62,916	4,319	83,607	150,842		150,842	14,632	165,474		6
7	Other (specify):*							75,591	75,591		7
8	TOTAL General Services	190,189	717,645	190,535	1,098,369		1,098,369	397,988	1,496,357		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	2,806,531	159,222	229,073	3,194,826		3,194,826	280,313	3,475,139		10
10a	Therapy	810,815	5,768	119,790	936,373		936,373		936,373		10a
11	Activities	92,903	3,436	10,126	106,465		106,465		106,465		11
12	Social Services	66,696		1,787	68,483		68,483		68,483		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,776,945	168,426	360,776	4,306,147		4,306,147	280,313	4,586,460		16
	C. General Administration										
17	Administrative	206,920	6,604	1,455,411	1,668,935		1,668,935	(574,085)	1,094,850		17
18	Directors Fees										18
19	Professional Services			246,105	246,105		246,105		246,105		19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses	148,594	7,030	41,822	197,446		197,446	(10,142)	187,304		21
22	Employee Benefits & Payroll Taxes			831,466	831,466		831,466	(494,328)	337,138		22
23	Inservice Training & Education										23
24	Travel and Seminar			48	48		48		48		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			110,338	110,338		110,338	(110,338)			26
27	Other (specify):*										27
28	TOTAL General Administration	355,514	13,634	2,685,190	3,054,338		3,054,338	(1,188,893)	1,865,445		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,322,648	899,705	3,236,501	8,458,854		8,458,854	(510,592)	7,948,262		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:

07/01/2013

Ending:

06/30/2014

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			390,819	390,819	390,819	(127,985)	262,834				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			180,579	180,579	180,579	(180,579)					32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			571,398	571,398	571,398	(308,564)	262,834				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		414,144		414,144	414,144		414,144				39
40	Barber and Beauty Shops			23,348	23,348	23,348		23,348				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			145,880	145,880	145,880		145,880				42
43	Other (specify):* Crosstown	180,898	328,612	517,580	1,027,090	1,027,090	722,558	1,749,648				43
44	TOTAL Special Cost Centers	180,898	742,756	686,808	1,610,462	1,610,462	722,558	2,333,020				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,503,546	1,642,461	4,494,707	10,640,714	10,640,714	(96,598)	10,544,116				45

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

Facility Name & ID Number Illini Restorative Care

0048264

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

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				5
6	Rented Facility Space	(53,496)	10		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(96)	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				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	(709)	3		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (54,301)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (54,301)		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: 07/01/2013

Ending: 06/30/2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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:

07/01/2013

Ending:

06/30/2014

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	202,907	0	0	0	0	0	0	0	0	0	202,907	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	104,858	0	0	0	0	0	0	0	0	0	104,858	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	14,632	0	0	0	0	0	0	0	0	0	14,632	6
7	Other (specify):*	0	75,591	0	0	0	0	0	0	0	0	0	75,591	7
8	TOTAL General Services	0	397,988	0	397,988	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	(53,496)	333,809	0	0	0	0	0	0	0	0	0	280,313	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(53,496)	333,809	0	280,313	16								
	C. General Administration													
17	Administrative	(96)	(573,989)	0	0	0	0	0	0	0	0	0	(574,085)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	(10,142)	0	0	0	0	0	0	0	0	0	(10,142)	21
22	Employee Benefits & Payroll Taxes	0	(494,328)	0	0	0	0	0	0	0	0	0	(494,328)	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	(110,338)	0	0	0	0	0	0	0	0	0	(110,338)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(96)	(1,188,797)	0	(1,188,893)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(53,592)	(457,000)	0	(510,592)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Illini Restorative Care# 0048264

Report Period Beginning:

07/01/2013 Ending:

06/30/2014

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	(127,985)	0	0	0	0	0	0	0	0	0	(127,985)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	(180,579)	0	0	0	0	0	0	0	0	0	(180,579)	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	0	(308,564)	0	(308,564)	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	722,558	0	0	0	0	0	0	0	0	0	722,558	43
44	TOTAL Special Cost Centers	0	722,558	0	722,558	44								
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(53,592)	(43,006)	0	0	0	0	0	0	0	0	0	(96,598)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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</u>	<u>Silvis</u>	<u>GMC Silvis</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>700,638</u>	<u>GMC Silvis (B Pt I Allocated Cost)</u>	<u>100.00%</u>	\$ <u>903,545</u>	\$ <u>202,907</u>	1
2	V	<u>4 Laundry</u>		<u>GMC Silvis (B Pt I Allocated Cost)</u>	<u>100.00%</u>	<u>104,858</u>	<u>104,858</u>	2
3	V	<u>6 Plant Op/Maintenance</u>		<u>GMC Silvis (B Pt I Allocated Cost)</u>	<u>100.00%</u>	<u>14,632</u>	<u>14,632</u>	3
4	V	<u>7 Cafeteria</u>		<u>GMC Silvis (B Pt I Allocated Cost)</u>	<u>100.00%</u>	<u>75,591</u>	<u>75,591</u>	4
5	V	<u>10 Medical Records & Nrsg Adm</u>		<u>GMC Silvis (B Pt I Allocated Cost)</u>	<u>100.00%</u>	<u>333,809</u>	<u>333,809</u>	5
6	V	<u>17 Administrative & General</u>	<u>1,915,040</u>	<u>GMC Silvis (B Pt I Allocated Cost)</u>	<u>100.00%</u>	<u>1,341,051</u>	<u>(573,989)</u>	6
7	V	<u>21 Clerical & General Office Exp</u>	<u>32,703</u>	<u>GMC Silvis (B Pt I Allocated Cost)</u>	<u>100.00%</u>	<u>22,561</u>	<u>(10,142)</u>	7
8	V	<u>22 Employee Benefits</u>	<u>831,466</u>	<u>GMC Silvis (B Pt I Allocated Cost)</u>	<u>100.00%</u>	<u>337,138</u>	<u>(494,328)</u>	8
9	V	<u>26 Insurance-Prop.Liab.Malpr</u>	<u>110,338</u>	<u>GMC Silvis (B Pt I Allocated Cost)</u>	<u>100.00%</u>		<u>(110,338)</u>	9
10	V	<u>30 CRC Bldgs & Fixt-Depr</u>	<u>390,819</u>	<u>GMC Silvis (B Pt I Allocated Cost)</u>	<u>100.00%</u>	<u>262,834</u>	<u>(127,985)</u>	10
11	V	<u>32 CRC Bldgs & Fixt-Interest</u>	<u>180,579</u>	<u>GMC Silvis (B Pt I Allocated Cost)</u>	<u>100.00%</u>		<u>(180,579)</u>	11
12	V	<u>43 Crosstown Square</u>	<u>538,710</u>	<u>GMC Silvis (B Pt I Allocated Cost)</u>	<u>100.00%</u>	<u>1,261,268</u>	<u>722,558</u>	12
13	V							13
14	Total		\$ <u>4,700,293</u>			\$ <u>4,657,287</u>	\$ * <u>(43,006)</u>	14

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	NOT APPLICABLE							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

Facility Name & ID Number Illini Restorative Care # 0048264 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	NOT APPLICABLE								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Illini Restorative Care

0048264 Report Period Beginning: 07/01/2013

Ending: 6/30/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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	NOT APPLICABLE				\$	\$		\$	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	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Illini Restorative Care

0048264

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

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		3	4	5	6		8	9	10						
		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	06/28/06	\$ 11,000,000	\$	07/08/11	0.0690	\$						
2	GMC Silvis	X		Mortgage	\$90,699.35	06/02/10	8,958,390	5,725,895	05/30/20	0.0400							
3																	
4																	
5																	
Working Capital																	
6																	
7																	
8																	
9	TOTAL Facility Related				\$176,069.35		\$ 19,958,390	\$ 5,725,895			\$						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 19,958,390	\$ 5,725,895			\$						

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

* 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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2013 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 2014 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:	2009	<u>N/A</u>	<u>8</u>	FOR BHF USE ONLY		
	2010	<u>N/A</u>	<u>9</u>			
	2011	<u>N/A</u>	<u>10</u>			
	2012	<u>N/A</u>	<u>11</u>			
	2013	<u>N/A</u>	<u>12</u>			
				13	FROM R. E. TAX STATEMENT FOR 2013 \$	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.

2013 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 2013 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 2013.

	(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	NOT APPLICABLE		\$	\$
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 and 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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.**

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 672,717	\$ 16,818	40	\$ 16,818	\$	\$ 391,016	4
5		2000		5,239,215	130,980	40	130,980		1,815,983	5
6										6
7										7
8										8
Improvement Type**										
9	Legal & Professional	1991		89,731	2,243	40	2,243		52,156	9
10	Field Tests	1991		1,547	39	40	39		899	10
11	Time & Material Work	1991		17,753	444	40	444		10,319	11
12	Kitchen Plan	1991		1,025	26	40	26		596	12
13	Co19,20,21,24,25,26,27,28(Htg/Vent/AC)	1991		27,371	684	40	684		15,909	13
14	Co29-Pipe Recepticals,Ect	1991		7,746	310	25	310		7,203	14
15	Co#23-Kitchen & Lounge	1991		40,623	1,016	40	1,016		23,612	15
16	Painting & Wallpaper	1991		2,032		5			2,032	16
17	Carpet & Tile	1991		1,622		5			1,622	17
18	Electrical Supplies	1991		396		10			396	18
19	3 Wall Pack Lights	1991		3,472		10			3,472	19
20	Co#15-Fire Exting&Cabinet	1991		1,106		15			1,106	20
21	Co#16,17-Paint/Whirlpool	1991		2,590		10			2,590	21
22	Co#18-Gutter & Downspouts	1991		3,929		15			3,929	22
23	Co#30-City Walk	1991		323		10			323	23
24	Co#33-Copper Wire	1991		3,981		20			3,981	24
25	Co.#31-2 Exit Light	1991		148		10			148	25
26	Co#32-Smoke Detect/Wiring	1991		1,605		10			1,605	26
27	Co.#1-7 Sewer Line&Overbed	1991		18,770		20			18,770	27
28	Co#9-Elevator Auto Ret Sy	1991		1,042		20			1,042	28
29	Co#8-14 (Exct9) Lights, Walk	1991		13,230		10			13,230	29
30	Est Nailers, Wood Trusses	1991		31,871		15			31,871	30
31	Cabin, Toilets, Doors, Handr	1991		57,912		15			57,912	31
32	Grade Insulation	1991		3,257		15			3,257	32
33	Roof System, Asphalt Shing	1991		36,118		10			36,118	33
34	Sheet Metal	1991		3,843		20			3,843	34
35	Wood Doors&Frames; Hardwar	1991		53,541		20			53,541	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:

07/01/2013

Ending:

06/30/2014

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	Metal Windows	1991	\$ 13,134	\$	20	\$	\$	\$ 13,134	37
38	Alum Entrances&Storefront	1991	7,608		20			7,608	38
39	Ceramic Tile	1991	3,575		20			3,575	39
40	Acoustic Ceilings	1991	23,090		15			23,090	40
41	Resil Floor&Base, Stair Tr	1991	11,340		10			11,340	41
42	Paint & Wall Covering	1991	32,200		5			32,200	42
43	Carpet	1991	18,550		5			18,550	43
44	Plumbing, Sprinkler Work	1991	211,741		20			211,741	44
45	Heating	1991	157,820		17			157,820	45
46	Air Conditioning	1991	133,565		17			133,565	46
47	Electrical	1991	128,975		20			128,975	47
48	Plumbing&Electrical Util	1991	44,800		20			44,800	48
49	Fans	1991	2,017		15			2,017	49
50	Lockers, Toilet Accessorie	1991	5,747		15			5,747	50
51	Cabinets, Casework	1991	23,231		20			23,231	51
52	Elevators	1991	13,665		20			13,665	52
53	Landscaping	1991	1,050		10			1,050	53
54	Concrete Curb&Walk, Aph Rd	1991	27,738		15			27,738	54
55	Landscaping	1991	9,100		10			9,100	55
56	Sign Electrical Feed	1991	1,209		20			1,209	56
57	Parking Curbs	1991	577		10			577	57
58	Sod	1991	1,945		10			1,945	58
59	Dining Room Sound System	1991	1,561		5			1,561	59
60	1 Sign 3'X10' Single Side	1991	3,826		12			3,826	60
61	Signs	1992	503		12			503	61
62	Nurses Station	1992	457		10			457	62
63	Nurse Call System	1992	2,043		15			2,043	63
64	Handrail and Door	1992	1,470		15			1,470	64
65	Door Access	1992	856		10			856	65
66	Cntrl Domestic Water Heat	1992	466		10			466	66
67	Wallpaper & Carpeting	1992	3,326		5			3,326	67
68	Smoke Door Holders	1992	779		10			779	68
69	Chandelier	1992	492		10			492	69
70	TOTAL (lines 4 thru 69)		\$ 7,226,969	\$ 152,559		\$ 152,559	\$	\$ 3,446,937	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:

07/01/2013

Ending:

06/30/2014

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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		\$ 7,226,969	\$ 152,559		\$ 152,559	\$	\$ 3,446,937	1
2	Alarm System	1992	587		15			587	2
3	Carpet	1992	438		5			438	3
4	Vinyl	1992	578		20			578	4
5	Crosstown Sign	1993	1,305		12			1,305	5
6	New Seeding/Mulch	1993	5,131		10			5,131	6
7	Circuit Panel, A/C Outlet	1993	930		10			930	7
8	Wanderguard Depart Alert	1993	3,117		10			3,117	8
9	Air Condition Installation	1994	498		10			498	9
10	Cs Carpet Apt #117	1994	690		5			690	10
11	Repair Sidewalk	1994	1,874		15			1,874	11
12	Handrails - Irc	1994	5,358		15			5,358	12
13	Window Coverings-Pt Area	1994	1,467		5			1,467	13
14	Sidewalk	1995	710		15			710	14
15	Tile & Base for Hallway	1995	2,183		10			2,183	15
16	Tile for Irc Hallway	1995	1,004		10			1,004	16
17	Irc Hall Tile Repair	1995	694		10			694	17
18	P.T. Utility Study	1995	142,758		15			142,758	18
19	Emerson Air Conditioner	1995	594		10			594	19
20	Drapes-Employee Lounge	1995	1,464		5			1,464	20
21	190 Gal Verticl Asme Tank	1996	2,650		10			2,650	21
22	Directory Board for Wall	1996	797		10			797	22
23	Hot Water Tank - Labor	1996	1,749		10			1,749	23
24	Carpet Apts 240 & 249	1996	1,440		5			1,440	24
25	Major Repairs Irc Boiler	1996	9,872		5			9,872	25
26	Parking Lot 4 Repairs-Irc	1996	3,561		8			3,561	26
27	Remodel Irc Nurse Station	1997	3,340		15			3,340	27
28	Cabinets/Storage-Utili Rm	1997	4,103		15			4,103	28
29	Air Compressor For Chillr	1997	14,196		15			14,196	29
30	Double Egress Wood Doors	1998	2,756		15			2,756	30
31	Lock Sets Mastered To Key	1998	2,642		5			2,642	31
32	Landscaping-Irc	1998	2,176		10			2,176	32
33	Carpet Lobby & Office Areas	1998	3,123		5			3,123	33
34	TOTAL (lines 1 thru 33)		\$ 7,450,753	\$ 152,559		\$ 152,559	\$	\$ 3,670,720	34

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

Facility Name & ID Number Illini Restorative Care

0048264

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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		\$ 7,450,753	\$ 152,559		\$ 152,559	\$	\$ 3,670,720	1
2	Tie-In Piping Hot Water To Irc	1998	1,766	88	20	88		1,369	2
3	VPI Base & Ceramic Tile	1999	1,385		10			1,385	3
4	Wood Replace Doors-Irc 4 Rooms	1999	1,308	87	15	87		1,264	4
5	4" Sprinkler	2000	18,675	747	25	747		10,831	5
6	Data Voice Wiring-SC	2000	31,453		10			31,453	6
7	Door Alarm-Sheltered Care	2000	2,211		10			2,211	7
8	Analog Message-Sheltered Care	2000	2,693		10			2,693	8
9	Air Cond/Handling Unit	2001	2,187		10			2,187	9
10	Kitchen Cabinets-Sc	2001	4,077	272	15	272		3,669	10
11	Irc Roof Hatches	2001	2,420		10			2,420	11
12	Nurse Call System-Sc	2001	6,498		10			6,498	12
13	Door and Door Closers Exam Rm	2001	1,524	102	15	102		1,372	13
14	Carpentry Patient Room Showers	2001	9,326	622	15	622		8,393	14
15	Irc Boiler Stack	2001	14,750	738	20	738		9,956	15
16	Concrete Replacement	2001	2,239	149	15	149		2,015	16
17	Paint Wallpaper Carpet, Act	2001	1,926		5			1,926	17
18	Pa System Irc Dining Room	2001	1,682		10			1,682	18
19	Door Wooden Irc	2001	1,465	98	15	98		1,221	19
20	Irc Bedpan Washers	2002	2,923	195	15	195		2,436	20
21	Irc Wall Hydrants	2002	1,354		10			1,354	21
22	Irc Wanderguard Relocation	2002	3,122		10			3,122	22
23	Medicare Rooms Wall Guards	2002	772		10			772	23
24	Ahu Valve Control Upgrade	2002	3,328		10			3,328	24
25	Irc Cooling Unit Controls	2002	4,567		10			4,567	25
26	Switchboard Cable Irc	2002	4,831		10			4,831	26
27	Boiler Fair Over Controls	2002	1,905		10			1,905	27
28	Irc Carpet Hallway	2002	10,072		5			10,072	28
29	Asphalt Parking Lot-Nw Area	2002	44,394		8			44,394	29
30	Parking Lot Lights NwArea	2002	9,535		10			9,535	30
31	Double Egress Door Replacement	2002	4,342	217	20	217		2,714	31
32	Bronze Circulating Pump	2003	1,937		10			1,937	32
33	Security System	2003	6,267		10			6,267	33
34	TOTAL (lines 1 thru 33)		\$ 7,657,686	\$ 155,873		\$ 155,873	\$	\$ 3,860,499	34

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

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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 12C, Carried Forward		\$ 7,657,686	\$ 155,873		\$ 155,873	\$	\$ 3,860,499	1
2	IRC Loading Dock	2003	97,613	3,905	25	3,905		44,902	2
3	Air Conditioning Unit	2003	2,755		7			2,755	3
4	IRC Door Alarm	2003	5,792		10			5,792	4
5	Canopy	2003	2,275	152	15	152		1,593	5
6	Architect Fees	2004	41,400	1,035	40	1,035		10,868	6
7	Blue Prints PT	2004	36	1	40	1		9	7
8	PT Construction	2004	80,180	2,005	40	2,005		21,047	8
9	PT Construction	2004	93,098	2,327	40	2,327		24,438	9
10	Wallcoverings	2004	490		5			490	10
11	Architect Fees IRC Laundry	2004	7,056	176	40	176		1,852	11
12	Blue Prints IRC Laundry	2004	122	3	40	3		32	12
13	Construction IRC Laundry	2004	24,446	611	40	611		6,417	13
14	Contract Services IRC Laundry	2004	60,362	1,509	40	1,509		15,845	14
15	rvs Arch Fees Already Cap	2004	(1,655)	(41)	40	(41)		(434)	15
16	Blue Prints IRC Laund Rvs	2004	(122)	(3)	40	(3)		(32)	16
17	Contract Serv IRC Laun Rvs	2004	(3,023)	(76)	40	(76)		(794)	17
18	Air Handling IRC Laundry	2004	19,065	953	20	953		10,009	18
19	Rvs Air Handling Cap FY03	2004	(19,065)	(953)	20	(953)		(10,009)	19
20	AIR/DIRT SEPARATOR	2004	4,905	491	10	491		4,660	20
21	BOILER REPLACEMENT DEAERATOR	2005	24,668	1,774	15	1,774		14,910	21
22	Roof	2005	51,860	5,186	10	5,186		44,081	22
23	Acuator Controls	2005	4,092	205	20	205		1,739	23
24	LANDSCAPING	2005	2,511	251	10	251		2,134	24
25	CONDUIT & WIRING	2005	1,539	77	20	77		654	25
26	CONSTRUCTION	2005	199,131	19,913	10	19,913		169,261	26
27	DESIGN FEES	2005	15,555	1,556	10	1,556		13,222	27
28	Valve Replacements	2006	12,432	622	20	622		5,284	28
29	DESIGN FEES	2006	1,601	160	10	160		1,361	29
30	HOLLOW METAL DOORS	2006	10,987	549	20	549		4,669	30
31	Drapes (Fabric & Sheer)	2006	2,304		5			2,304	31
32	Electric Switch Gear	2006	3,719	248	15	248		1,859	32
33	IRC Boiler Tank	2008	3,373	337	10	337		2,192	33
34	TOTAL (lines 1 thru 33)		\$ 8,407,188	\$ 198,845		\$ 198,845	\$	\$ 4,263,611	34

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

Facility Name & ID Number Illini Restorative Care

0048264

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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 12D, Carried Forward		\$ 8,407,188	\$ 198,845		\$ 198,845	\$	\$ 4,263,611	1
2	Repair Sidewalk LSC Survey	2008	2,257	150	15	150		978	2
3	Door Hold - Magnetic	2008	1,404	140	10	140		772	3
4	Nurse Call System	2008	54,966	5,497	10	5,497		30,231	4
5	Air Conditioning/Cooling	2008	4,050	405	5	405		4,050	5
6	Boiler Replacement	2008	432,708	21,635	20	21,635		118,995	6
7	IRC Boiler Replacement	2008	99,083	5,828	17	5,828		32,056	7
8	Replace Nurse Call System	2008	60,202	6,020	10	6,020		33,111	8
9	Fire Damper Doors LSC Survey	2008	7,877	394	20	394		2,166	9
10	Replace Asphalt Entry Drive	2008	23,800	1,587	15	1,587		8,727	10
11	Replace Cooridor Doors	2009	15,509	1,034	15	1,034		5,687	11
12	Magnetic Door Holder	2009	1,334	133	10	133		734	12
13	Replace Fire Alarm Panel	2009	62,446	6,245	10	6,245		34,345	13
14	Domestic Hot Water Pumps	2009	56,488	3,766	15	3,766		16,946	14
15	Replace Chiller Module IRC N	2009	14,723	1,472	10	1,472		6,625	15
16	Sprinkler System Internal	2010	50,187	2,007	25	2,007		9,034	16
17	Remodel 8 Private Rooms	2010	44,255	2,950	15	2,950		13,276	17
18	Remodel 8 Private Rooms	2010	7,888	1,578	5	1,578		7,099	18
19	Emerg Power IRC Pt Rooms	2010	15,721	1,048	15	1,048		4,716	19
20	Replace Old Roof Section - IRC	2011	122,994	12,299	10	12,299		30,749	20
21	Storm Sewer Repair	2011	4,434	177	25	177		443	21
22	Air Conditioner Replace IRC	2011	5,265	351	15	351		878	22
23	Upgrade Entrances to Handicap	2011	10,023	1,002	10	1,002		2,506	23
24	Handicap Door Access	2011	2,867	287	10	287		717	24
25	Lighting for IRC	2012	10,519	1,052	10	1,052		2,630	25
26	Add AC Units to Cool Offices	2012	13,450	1,345	10	1,345		3,363	26
27	Feed Wiring for New Sign	2012	1,250	63	20	63		156	27
28	New Freestanding Sign	2012	5,905	591	10	591		1,476	28
29	IRC Patient Room Upgrades	2012	25,676	2,568	10	2,568		3,851	29
30	IRC Patient Room Upgrades	2012	11,106	740	15	740		1,111	30
31	IRC Patient Room Upgrades	2012	191,619	9,581	20	9,581		14,371	31
32	Sink for Soiled Utility Room	2012	9,165	458	20	458		687	32
33	IRC Patient Room Upgrades	2012	8,362	1,672	5	1,672		2,509	33
34	TOTAL (lines 1 thru 33)		\$ 9,784,719	\$ 292,922		\$ 292,922	\$	\$ 4,658,605	34

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

Facility Name & ID Number Illini Restorative Care

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 9,784,719	\$ 292,922		\$ 292,922	\$	\$ 4,658,605	1
2	Resurface IRC Parking Lot	2012	16,117	2,015	8	2,015		3,022	2
3	Therapy Equipment IRC	2012	2,167	144	15	144		217	3
4	Replace Sidewalks	2012	15,535	1,036	15	1,036		1,554	4
5	Renovation of Shelter/Medicare	2013	6,097	1,219	5	1,219		1,829	5
6	Renovation of Shelter/Medicare	2013	178,023	17,802	10	17,802		26,703	6
7	Renovation of Bath and Station	2013	2,139	214	10	214		321	7
8	Replace Failed Boiler IRC N	2013	31,353	784	20	784		784	8
9	Keypad Release Lock	2013	6,776	678	5	678		678	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,042,926	\$ 316,814		\$ 316,814	\$	\$ 4,693,712	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 579,960	\$ 59,289	\$ 59,289	\$		\$ 358,050	71
72	Current Year Purchases	190,406	14,716	14,716			14,716	72
73	Fully Depreciated Assets	624,449					624,449	73
74								74
75	TOTALS	\$ 1,394,816	\$ 74,005	\$ 74,005	\$		\$ 997,215	75

D. Vehicle Costs. (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)	\$ 11,471,184	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 390,819	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 390,819	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,690,927	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>			\$ _____			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ _____			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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

* 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.

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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER 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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39	# of prescrpts				414,144		414,144	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			\$		\$	\$ 414,144		\$ 414,144	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: 07/01/2013

Ending:

06/30/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2014

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 256,518	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,715,229		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	118,728		8
9	Other(specify): <u>Due From Affiliates</u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,090,475	\$	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	14,473,588		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,205,488		16
17	Accumulated Depreciation (book methods)	(9,694,365)		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>	41,070		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,083,504	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,173,979	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 175,597	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	875,288		29
30	Accrued Salaries Payable	352,466		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,721		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 & Third Party Payable</u>	280,195		36
37	<u>Other Accrued Expenses</u>	188,716		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,880,983	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,850,607		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)	\$ 4,850,607	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,731,590	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,442,389	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,173,979	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,843,116	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,843,116	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(501,329)	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) Interest Income	5,244	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (496,085)	17
B. Transfers (Itemize):			
18	Equity Transfers	1,095,358	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 1,095,358	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,442,389	24 *

* This must agree with page 17, line 47.

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 14,878,926	1
2	Discounts and Allowances for all Levels	(4,877,872)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,001,054	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	84,731	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	53,496	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	104	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)	\$ 138,331	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,139,385	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,098,369	31
32	Health Care	4,306,147	32
33	General Administration	3,054,338	33
B. Capital Expense			
34	Ownership	571,398	34
C. Ancillary Expense			
35	Special Cost Centers	1,610,462	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,640,714	40
41	Income before Income Taxes (line 30 minus line 40)**	(501,329)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (501,329)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

* 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: 07/01/2013

Ending: 06/30/2014

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	1,580	1,744	\$ 63,326	\$ 36.31	1
2	Assistant Director of Nursing					2
3	Registered Nurses	34,437	38,005	983,263	25.87	3
4	Licensed Practical Nurses	21,608	23,594	418,579	17.74	4
5	CNAs & Orderlies	90,351	98,350	1,228,593	12.49	5
6	CNA Trainees					6
7	Licensed Therapist	17,818	18,862	629,457	33.37	7
8	Rehab/Therapy Aides	13,755	15,434	293,468	19.01	8
9	Activity Director	2,012	2,214	38,672	17.47	9
10	Activity Assistants	4,994	5,434	66,904	12.31	10
11	Social Service Workers	3,103	3,558	72,419	20.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,850	4,870	91,428	18.77	17
18	Housekeepers	12,386	13,819	166,066	12.02	18
19	Laundry					19
20	Administrator	3,513	3,973	217,490	54.74	20
21	Assistant Administrator	360	386	8,654	22.42	21
22	Other Administrative	1,210	1,272	31,771	24.98	22
23	Office Manager					23
24	Clerical	10,113	11,021	193,456	17.55	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)	222,090	242,536	\$ 4,503,546 *	\$ 18.57	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	
Glenwood Roebuck	Exec Director		\$ 65,564	Workers' Compensation Insurance	\$ 16,584	IDPH License Fee	\$	
DeShawn Schmidt	Administrator, Senior Svc		48,889	Unemployment Compensation Insurance	5,391	Advertising: Employee Recruitment		
Debra Slater	Administrator, Senior Svc		81,716	FICA Taxes	257,275	Health Care Worker Background Check		
Debbie Pontsler	Asst, Executive		7,971	Employee Health Insurance	316,195	(Indicate # of checks performed)		
Jay Hillgartner	Coordinator		2,780	Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*				
				Pension	89,635			
				Employee Assistance Program	5,978			
				Long Term Disability	17,644			
				Life Insurance	6,250			
				Tuition Reimbursement	116,514			
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 206,920	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other								
Description			Amount					
Corporate Allocations			\$ 1,433,462					
Dues			7,667					
Other Administrative			14,282					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,455,411					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Health Dimensions Con	Nursing Home Operations		\$ 218,085				Out-of-State Travel	\$
HDG	Nursing Home Operations		7,661					
Wescom Solutions	Other		18,746				In-State Travel	
National Research Cor	Other		1,613				Education & Travel	48
							Seminar Expense	
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 246,105	TOTAL		\$	TOTAL	\$ 48

* Attach copy of IMRF notifications

**See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	NOT APPLICABLE	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Illini Restorative Care# 0048264Report Period Beginning: 07/01/2013 Ending: 06/30/2014**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council Long Term Care \$7667
- (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. \$ 5,257 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. \$ 145,880
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: 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.