

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: 0055756

Facility Name: Illini Restorative Care

Address: 1455 Hospital Rd Silvis 61282
Number City Zip Code

County: Rock Island

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

HFS ID Number:

Date of Initial License for Current Owners: 08/12/1991

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Karen Klug Telephone Number: (515) 271-6861
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the
State of Illinois, for the period from 01/01/2020 to 12/31/2020
and certify to the best of my knowledge and belief that the said contents
are true, accurate and complete statements in accordance with
applicable instructions. Declaration of preparer (other than provider)
is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information
in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Peg Moses
(Title) Controller

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) Deborah Emerson
Principal
(Firm Name & Address) CliftonLarsonAllen LLP
9365 Counselors Row, Suite 200, Indianapolis, IN 46240
(Telephone) 317-569-6230 Fax # 317-574-9707

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Illini Restorative Care

0055756 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>92</u>	Skilled (SNF)	<u>92</u>	<u>33,672</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>28</u>	Sheltered Care (SC)	<u>28</u>	<u>10,248</u>	5
6		ICF/DD 16 or Less			6
7	<u>120</u>	TOTALS	<u>120</u>	<u>43,920</u>	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>8,652</u>	<u>7,518</u>	<u>5,774</u>	<u>21,944</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		<u>3,488</u>		<u>3,488</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,652</u>	<u>11,006</u>	<u>5,774</u>	<u>25,432</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.91%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 92 and days of care provided 2,679

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Illini Restorative Care # 0055756 Report Period Beginning: 01/01/2020 Ending: 12/31/2020
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		6,556	670,296	676,852		676,852	(2,047)	674,805			1
2	Food Purchase		63,183		63,183		63,183		63,183			2
3	Housekeeping		51	3,732	3,783		3,783		3,783			3
4	Laundry		11,220	95,999	107,219		107,219		107,219			4
5	Heat and Other Utilities			182,074	182,074		182,074		182,074			5
6	Maintenance		32,888	259,387	292,275		292,275		292,275			6
7	Other (specify):*											7
8	TOTAL General Services		113,898	1,211,488	1,325,386		1,325,386	(2,047)	1,323,339			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	3,030,538	379,437	490,829	3,900,804		3,900,804		3,900,804			10
10a	Therapy	479,973	5,391	17,598	502,962		502,962		502,962			10a
11	Activities	97,017	5,549	6,279	108,845		108,845		108,845			11
12	Social Services	80,857			80,857		80,857		80,857			12
13	CNA Training											13
14	Program Transportation			10,270	10,270		10,270		10,270			14
15	Other (specify):* Marketing	20,899	219	19,288	40,406		40,406	(40,406)				15
16	TOTAL Health Care and Programs	3,709,284	390,596	544,264	4,644,144		4,644,144	(40,406)	4,603,738			16
	C. General Administration											
17	Administrative	61,284	18,524	600,800	680,608	47,733	728,341	(210,813)	517,528			17
18	Directors Fees											18
19	Professional Services			7,281	7,281		7,281		7,281			19
20	Dues, Fees, Subscriptions & Promotions			43,978	43,978		43,978		43,978			20
21	Clerical & General Office Expenses	124,498		321,643	446,141	(33,499)	412,642		412,642			21
22	Employee Benefits & Payroll Taxes			780,976	780,976		780,976		780,976			22
23	Inservice Training & Education			3,596	3,596		3,596		3,596			23
24	Travel and Seminar			14,234	14,234	(14,234)						24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			108,554	108,554		108,554		108,554			26
27	Other (specify):* Bad Debt Exp			504,685	504,685		504,685	(504,685)				27
28	TOTAL General Administration	185,782	18,524	2,385,747	2,590,053		2,590,053	(715,498)	1,874,555			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,895,066	523,018	4,141,499	8,559,583		8,559,583	(757,951)	7,801,632			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			113,916	113,916		113,916		113,916			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Intangible Assets			17,416	17,416		17,416	(17,416)				36
37	TOTAL Ownership			131,332	131,332		131,332	(17,416)	113,916			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			209,530	209,530		209,530		209,530			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			177,696	177,696		177,696		177,696			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			387,226	387,226		387,226		387,226			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,895,066	523,018	4,660,057	9,078,141		9,078,141	(775,367)	8,302,774			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,047)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				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	(504,685)	27		24
25	Fund Raising, Advertising and Promotional	(40,406)	15		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	(228,229)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (775,367)		\$	30

BHF USE ONLY								
48		49		50		51		52

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
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (775,367)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Distribution- Miscellaneous Revenue	\$ (210,813)	17	1
2	Intangible Amortization	(17,416)	36	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	(228,229)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Illini Restorative Care # 0055756 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	(2,047)	0	0	0	0	0	0	0	0	0	0	(2,047)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,047)	0	0	0	0	0	0	0	0	0	0	(2,047)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(40,406)	0	0	0	0	0	0	0	0	0	0	(40,406)	15
16	TOTAL Health Care and Programs	(40,406)	0	0	0	0	0	0	0	0	0	0	(40,406)	16
	C. General Administration													
17	Administrative	(210,813)	0	0	0	0	0	0	0	0	0	0	(210,813)	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	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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):*	(504,685)	0	0	0	0	0	0	0	0	0	0	(504,685)	27
28	TOTAL General Administration	(715,498)	0	0	0	0	0	0	0	0	0	0	(715,498)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(757,951)	0	0	0	0	0	0	0	0	0	0	(757,951)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Illini Restorative Care # 0055756 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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):*	(17,416)	0	0	0	0	0	0	0	0	0	0	(17,416)	36
37	TOTAL Ownership	(17,416)	0	0	0	0	0	0	0	0	0	0	(17,416)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(775,367)	0	0	0	0	0	0	0	0	0	0	(775,367)	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
WesleyLife	60	Westwing	DeWitt, IA			
Genesis	40					

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		Management Fee	\$ 600,800	WesleyLife	60.00%	\$ 600,800	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 600,800			\$ 600,800	\$ *	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 # 0055756 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 # 0055756 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

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

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	Not Applicable						\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$	15

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

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2020 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:		2015	N/A	8	
		2016	N/A	9	
		2017	N/A	10	
		2018	N/A	11	
		2019	N/A	12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2019 \$ 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.

FACILITY NAME Illini Restorative Care COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0055756

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

Enter the tax index number and real estate tax assessed for 2019 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 2019.

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.)

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

A. Square Feet:

220,901

B. General Construction Type:

Exterior

Frame

Number of Stories

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☐

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	220,901	1993 & 1999	\$ 79,100	1
2					2
3	TOTALS	220,901		\$ 79,100	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120		2019		\$ 3,920,900	\$ 98,023	40	\$ 98,023	\$	\$ 147,034	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Regional Director Office		2020		5,967	852	7	852		852	9
10	IRC North Dock Painting		2020		15,591	2,227	7	2,227		2,227	10
11	Update Door Signage		2020		1,528	164	7	164		164	11
12	Repair to IntelliSwitch		2020		15,376	128	30	128		128	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

*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

0055756

Report Period Beginning:

01/01/2020 Ending: 12/31/2020

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,959,362	\$ 101,394		\$ 101,394	\$	\$ 150,405	70

**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	\$ 49,047	\$ 7,134	\$ 7,134	\$		\$ 9,568	71
72	Current Year Purchases	243,634	5,388	5,388			5,388	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 292,681	\$ 12,522	\$ 12,522	\$		\$ 14,956	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	4,331,143
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	113,916
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	113,916
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	165,361

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	CIP	\$ 12,613
93		
94		
95		\$ 12,613

* 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:	NA			\$			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?
16. Rental Amount for movable equipment: \$ Description:
- ☐ YES☐ NO
- (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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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)	\$			

- (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.

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	

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
	Service	Schedule V Line & Column Reference	2	3	4		5	6	7	8
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							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	39-3	# of prescrpts				197,147		197,147	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39-3					12,383		12,383	12
13	Other (specify): _____									13
14	TOTAL			\$		\$	\$ 209,530		\$ 209,530	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.

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	\$ 1,376,714	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 570,546)	1,479,423		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	5,291,127		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	102,341		7
8	Accounts Receivable (owners or related parties)	339		8
9	Other(specify): Resident Trust Account	309		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,250,253	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	79,100		13
14	Buildings, at Historical Cost	3,959,362		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	292,681		16
17	Accumulated Depreciation (book methods)	(165,362)		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 (spe Intangible Asset	229,127		22
23	Other(specify): Construction in Progress	12,613		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,407,521	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 12,657,774	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 891,317	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	186,505		30
31	Accrued Taxes Payable (excluding real estate taxes)	337,361		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	Accrued Other	663,463		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,078,646	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Related Party	532,876		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 532,876	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,611,522	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 10,046,252	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 12,657,774	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 11,214,948	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 11,214,948	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,301,425)	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) PY Adjustment	57,749	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,243,676)	17
	B. Transfers (Itemize):		
18			18
19	Genesis Equity	74,980	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 74,980	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 10,046,252	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Illini Restorative Care

0055756

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

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	\$ 6,797,895	1
2	Discounts and Allowances for all Levels	(2,331,159)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,466,736	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,862,150	6
7	Oxygen	79,745	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,941,895	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	511	13
14	Non-Patient Meals	2,047	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	367,977	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,905	19
20	Radiology and X-Ray	588	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 398,028	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	377,339	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 377,339	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Revenue	210,813	28
28a	COVID PRF	381,905	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 592,718	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,776,716	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,325,386	31
32	Health Care	4,644,144	32
33	General Administration	2,590,053	33
	B. Capital Expense		
34	Ownership	131,332	34
	C. Ancillary Expense		
35	Special Cost Centers	387,226	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)*	\$ 9,078,141	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,301,425)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,301,425)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,525,392	44
45	Private Pay - Net Inpatient Revenue	2,056,304	45
46	Medicare - Net Inpatient Revenue	885,040	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,466,736	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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.

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	2,160	2,160	\$ 117,831	\$ 54.55	1
2	Assistant Director of Nursing	4,320	4,320	169,745	39.29	2
3	Registered Nurses	24,917	24,917	563,338	22.61	3
4	Licensed Practical Nurses	27,104	27,104	457,837	16.89	4
5	CNAs & Orderlies	121,266	121,266	1,360,229	11.22	5
6	CNA Trainees					6
7	Licensed Therapist	15,928	15,928	479,973	30.13	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,995	6,995	83,500	11.94	10
11	Social Service Workers	3,337	3,337	83,426	25.00	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	3,128	3,128	109,017	34.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,520	6,520	124,498	19.09	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 C: MDS	8,146	8,146	323,160	39.67	32
33	Other(specify) Marketing	1,136	1,136	22,512	19.82	33
34	TOTAL (lines 1 - 33)	224,957	224,957	\$ 3,895,066 *	\$ 17.31	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	1,099	\$ 65,447	10-3	50
51	Licensed Practical Nurses	2,406	114,880	10-3	51
52	Certified Nurse Assistants/Aides	8,419	249,681	10-3	52
53	TOTAL (lines 50 - 52)	11,924	\$ 430,008		53

Facility Name & ID Number

Illini Restorative Care

STATE OF ILLINOIS

0055756

Report Period Beginning:

01/01/2020

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Ending: 12/31/2020

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	
Julie VanWinkle	Director		\$ 61,284	Workers' Compensation Insurance	\$ 65,749	IDPH License Fee	\$	
				Unemployment Compensation Insurance	79,961	Advertising: Employee Recruitment	18,472	
				FICA Taxes	291,040	Health Care Worker Background Check	4,208	
				Employee Health Insurance	196,345	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*				
				Disability	19,513	Dues & Memberships	16,909	
				Life Insurance	7,789	Subscriptions	2,399	
				Pension/ 401K	41,912	Permits/Fees	1,990	
				Wellness	78,667			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 61,284	TOTAL (agree to Schedule V, line 22, col.8)		\$ 780,976		
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	
Management Fees			\$ 600,800				Out-of-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 600,800				In-State Travel	
C. Professional Services								
Vendor/Payee	Type		Amount					
Dorsey & Whitney	Legal		\$ 6,132					
Optima Healthcare	Cloud service		1,125					
ComPsych	Employee Assistance Program		24					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 7,281	TOTAL		\$	Entertainment Expense	
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	

* Attach copy of IMRF notifications

**See instructions.

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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?

No

If YES, give association name and amount. N/A

(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? N/A

(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? N/A

(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.

\$ Line

(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. N/A

(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.

N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 177,696

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. \$ N/A

(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. \$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

0

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name: CliftonLarsonAllen LLP

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.

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