		FOR BHF USE				

LL1

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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: 0022996

Facility Name: Iona Glos SLC

Address: 50 S Fairbank St (Number) Addison (City) 60101 (Zip Code)

County: DuPage

Telephone Number: (630) 620-2222 **Fax #** (630) 628-1488

HFS ID Number:

Date of Initial License for Current Owners: November 18, 1980

Type of Ownership:

- [X] **VOLUNTARY,NON-PROFIT**
  - [X] Charitable Corp.
  - [ ] Trust
- **IRS Exemption Code**
- [ ] **PROPRIETARY**
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] **GOVERNMENTAL**
  - [ ] State
  - [ ] County
  - [ ] Other

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2012 to 06/30/2013 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)	Carmel A. Cooke
	(Title)	Chief Financial Officer
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	
	(Firm Name & Address)	
	(Telephone)	( ) Fax # ( )

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

In the event there are further questions about this report, please contact:
Name: Jaime Almonte Telephone Number: (630) 628-7260
Email Address:

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	100	Intermediate/DD	100	36,600	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,600	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	35,914			35,914	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,914			35,914	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.13%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

______

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 11/18/80

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date ______ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified ______ and days of care provided ______

Medicare Intermediary ______

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: June 30 Fiscal Year: June 30

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

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	134,454		19,059	153,513		153,513		153,513			1
2	Food Purchase		341,878		341,878		341,878		341,878			2
3	Housekeeping	3,840	122,950	78,960	205,750		205,750	(24,211)	181,539			3
4	Laundry											4
5	Heat and Other Utilities			124,176	124,176		124,176	(167)	124,009			5
6	Maintenance	148,111	92,957		241,068		241,068	(680)	240,388			6
7	Other (specify):* waste removal			31,472	31,472		31,472		31,472			7
8	TOTAL General Services	286,405	557,785	253,667	1,097,857		1,097,857	(25,058)	1,072,799			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	940,789	80,383	17,307	1,038,479		1,038,479		1,038,479			10
10a	Therapy	1,384,067			1,384,067		1,384,067		1,384,067			10a
11	Activities	33,074	26,111		59,185		59,185		59,185			11
12	Social Services											12
13	CNA Training	34,376	825		35,201		35,201		35,201			13
14	Program Transportation			58,736	58,736		58,736		58,736			14
15	Other (specify):* license/vertif & sch XVIII		675	28,020	28,695		28,695		28,695			15
16	TOTAL Health Care and Programs	2,392,306	107,994	104,063	2,604,363		2,604,363		2,604,363			16
	C. General Administration											
17	Administrative	580,837			580,837		580,837	(14,944)	565,893			17
18	Directors Fees											18
19	Professional Services			105,157	105,157		105,157	(72,631)	32,526			19
20	Dues, Fees, Subscriptions & Promotions			20,432	20,432		20,432	(1,180)	19,252			20
21	Clerical & General Office Expenses	355,800	51,273		407,073	(20,758)	386,315	(2,125)	384,190			21
22	Employee Benefits & Payroll Taxes			813,719	813,719		813,719	(4,185)	809,534			22
23	Inservice Training & Education			3,596	3,596		3,596	(484)	3,112			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			2,111	2,111		2,111	(295)	1,816			25
26	Insurance-Prop.Liab.Malpractice			62,518	62,518		62,518	(40)	62,478			26
27	Other (specify):* see worksheet 3			59,889	59,889		59,889	(52,936)	6,953			27
28	TOTAL General Administration	936,637	51,273	1,067,422	2,055,332	(20,758)	2,034,574	(148,820)	1,885,754			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,615,348	717,052	1,425,152	5,757,552	(20,758)	5,736,794	(173,878)	5,562,916			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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			315,497	315,497		315,497	(1,784)	313,713			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			344	344		344	(344)				33
34	Rent-Facility & Grounds			84,045	84,045		84,045	(5,803)	78,242			34
35	Rent-Equipment & Vehicles					20,758	20,758		20,758			35
36	Other (specify):*											36
37	**TOTAL Ownership**			399,886	399,886	20,758	420,644	(7,931)	412,713			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			348,760	348,760		348,760		348,760			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			348,760	348,760		348,760		348,760			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,615,348	717,052	2,173,798	6,506,198		6,506,198	(181,809)	6,324,389			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 Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 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				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,784)	30		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	(72,631)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,985)	27		24
25	Fund Raising, Advertising and Promotional	(53,724)	pg5A		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(344)	pg5A		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(50,341)	pg5A		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (181,809)		$	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 Amount	2 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	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (181,809)		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 Yes	2 No	3 Amount	4 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

STATE OF ILLINOIS

Iona Glos SLC

ID# 0022996

Report Period Beginning: 07/01/2012

Ending: 06/30/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Adjustment for Fundraising =50% of Development	$		1
2	also see Worksheet 1			2
3				3
4	Supplies	(24,211)	3	4
5	Utilities	(167)	5	5
6	Maintenance	(680)	6	6
7	Administrative	(14,944)	17	7
8	Publications	(110)	20	8
9	Marketing materials	(326)	20	9
10	Networking	(9)	20	10
11	Memberships	(462)	20	11
12	Advertisements	(273)	20	12
13	Clerical and General Office	(2,125)	21	13
14	Employee Benefits and Payroll Taxes	(4,185)	22	14
15	In Service Training & Education	(94)	23	15
16	Travel	(295)	25	16
17	Insurance	(40)	26	17
18	Rent	(5,803)	34	18
19	Total Fundraising adjustment			19
20	-53724			20
21				21
22	Other Non Allowables & Adjustments			22
23	Conferences and Seminar	(390)	23	23
24	Agency Functions	(49,642)	27	24
25	Fines, Penalties & Late Fees	(309)	27	25
26	Real Estate Taxes - Vacant Properties	(344)	33	26
27	Total Other Non-Allowables & Adjustments			27
28	-50685			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**	(104,409)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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

	Operating Expenses A. General Services	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)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	(24,211)	0	0	0	0	0	0	0	0	0	0	(24,211)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(167)	0	0	0	0	0	0	0	0	0	0	(167)	5
6	Maintenance	(680)	0	0	0	0	0	0	0	0	0	0	(680)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(25,058)	0	0	0	0	0	0	0	0	0	0	(25,058)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(14,944)	0	0	0	0	0	0	0	0	0	0	(14,944)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(72,631)	0	0	0	0	0	0	0	0	0	0	(72,631)	19
20	Fees, Subscriptions & Promotions	(1,180)	0	0	0	0	0	0	0	0	0	0	(1,180)	20
21	Clerical & General Office Expenses	(2,125)	0	0	0	0	0	0	0	0	0	0	(2,125)	21
22	Employee Benefits & Payroll Taxes	(4,185)	0	0	0	0	0	0	0	0	0	0	(4,185)	22
23	Inservice Training & Education	(484)	0	0	0	0	0	0	0	0	0	0	(484)	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(295)	0	0	0	0	0	0	0	0	0	0	(295)	25
26	Insurance-Prop.Liab.Malpractice	(40)	0	0	0	0	0	0	0	0	0	0	(40)	26
27	Other (specify):*	(52,936)	0	0	0	0	0	0	0	0	0	0	(52,936)	27
28	**TOTAL General Administration**	(148,820)	0	0	0	0	0	0	0	0	0	0	(148,820)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(173,878)	0	0	0	0	0	0	0	0	0	0	(173,878)	29

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(1,784)	0	0	0	0	0	0	0	0	0	0	(1,784)	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	(344)	0	0	0	0	0	0	0	0	0	0	(344)	33
34	Rent-Facility & Grounds	(5,803)	0	0	0	0	0	0	0	0	0	0	(5,803)	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**	(7,931)	0	0	0	0	0	0	0	0	0	0	(7,931)	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)**	(181,809)	0	0	0	0	0	0	0	0	0	0	(181,809)	45

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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
Not for Profit Corp - board members DO NOT have ownership in Ray Graham Association						

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		N/A	$			$	$	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			$			$	$ *	14

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

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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								1
2	Page 29 for addresses and other details							2
3	Chirperson - Mary Kay Rizzolo Mann	BOD						3
4	Vice Chairperson - Michael Komoll	BOD						4
5	Immediate Past Chair - Laura Sakas	BOD						5
6	Secretary/Treasurer - Lou Leonardi, III	BOD						6
7								7
8	Member at Large - Lee Jorwic	BOD						8
9	Member at Large - Deanna Wilkins	BOD						9
10								10
11	Directors							11
12	Neville Bimimoria	BOD						12
13	Joseph Derezinski	BOD						13
14	Jane Kaufman	BOD						14
15	Chris Nybo	BOD						15
16	Jeff Park	BOD						16
17	Richard Phelan	BOD						17
18	Jonathan Phillips	BOD						18
19	Mary Alice Povolny	BOD						19
20	Robert F. Spahn	BOD						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 Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	NONE								$		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 Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2012 Ending: 6/30/2013

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		See worksheet 1	direct cost			$	$		$ 910,776	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					$	$		$ 910,776	25

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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							$	$			$	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. $ Zero Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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 2012 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 2013 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:

Year	Amount	Line
2008		8
2009		9
2010		10
2011		11
2012		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Iona Glos SLC COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0022996

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 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 47,000 B. General Construction Type: Exterior brick Frame Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (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			1975	$ 214,674	1
2					2
3	TOTALS			$ 214,674	3

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	100		1980	1980	$ 3,681,931	$ 92,048		$ 92,048	$	$ 2,991,569	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SLC Direct										9
10											10
11	Prior Fiscal Years			2007	104,703	10,470		10,470		65,034	11
12				2008	421,828	43,503		43,503		215,059	12
13				2009	157,860	17,193		17,193		68,882	13
14	Kitchen Renovation, new cabinets, stainless steel sinks			2010	4,173	835		835		2,921	14
15	Replace circuit board			2010	1,152	230		230		806	15
16	Replace d gas regulator			2010	610	122		122		427	16
17	SLC Core Building roof replaced			2010	61,179	6,118		6,118		21,413	17
18	Raise and Support sidewalks			2010	975	195		195		683	18
19	New Counter Tops, Sink, Faucet			2010	1,932	386		386		966	19
20	Sidewalk Repair			2010	1,197	239		239		599	20
21	Replace door, SLC Training Room			2010	2,138	428		428		1,069	21
22	Carpet tiles - SLC Training Room			2010	559	112		112		280	22
23	Block Heaters			2010	12,741	2,548		2,548		6,371	23
24	Installed Sprinkler systems and fire alarm devices - all 6 Homes			2011	404,328	40,433		40,433		101,082	24
25	Bathroom Renovations -removed existing tile walls and flooring			2011	102,933	10,293		10,293		25,733	25
26	Replace kitchen counter top, sink and faucet - Home 1			2011	743	149		149		372	26
27	Remove and replace asphalt at dumpster			2011	590	118		118		295	27
28	Home 2 condensing unit replaced			2011	2,890	578		578		867	28
29	Home 1 Condensing unit replaced			2011	6,100	1,220		1,220		1,830	29
30	Install new threshold, reglaze double doors			2011	1,189	238		238		357	30
31	Lexan Plexiglas Window			2011	1,613	323		323		484	31
32	Furnace Blower motor replaced Home 1			2012	943	189		189		283	32
33	Furnace Motor and capacitor replaced			2012	712	142		142		214	33
34	Honeywell controller, damper actuator boiler replaced			2012	4,191	838		838		1,257	34
35	Shower valve replaced - Home 5			2012	545	109		109		164	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 Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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	Bradford 75 Gallon Water Heater - SLC Home 2	2012	$ 1,768	$ 354		$ 354	$	$ 530	37
38	SLC Rehab Cd10-24c Floors, Windows, paintings of 6 homes	2012	344,845	34,484		34,484		51,727	38
39	A/C Compressor Module Board & Switch Replaced	2012	1,730	346		346		519	39
40	Install and Hook Up Dishwasher	2012	2,137	427		427		641	40
41	A/C Install SLC Home 3	2012	1,202	120		120		120	41
42	5 Ton Condenser A/C SLC Home 3	2012	2,000	200		200		200	42
43	Replaced Condensing Unit SLC Home 5	2012	792	79		79		79	43
44	Two-Handle Slop Sink Faucet and New Rough Plumbing S	2012	1,189	119		119		119	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)		$ 5,335,418	$ 265,187		$ 265,187	$	$ 3,562,952	70

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

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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	
1	Totals from Page 12A, Carried Forward		$ 5,335,418	$ 265,187		$ 265,187	$	$ 3,562,952	1
2									2
3	EQUIPMENT DEPRECIATION								3
4									4
5	Purchase in Prior Years								5
6	SLC Direct - FFE		185,384	11,153		11,153		12,732	6
7									7
8	Management & General								8
9	Administration - FFE		51,701	10,072		10,072		38,885	9
10	SLC Portion of Administration (29.88%)		15,450	3,010		3,010		11,620	10
11									11
12	Employee Services FFE		6,890	1,047		1,047		6,890	12
13	SLC Portion of Employee Services (29.92%)		2,061	313		313		2,061	13
14									14
15	Finance FFE		29,649	8,562		8,562		15,723	15
16	SLC portion of Finance (29.85%)		8,851	2,556		2,556		4,694	16
17									17
18	Development FFE		5,235	873		873		5,235	18
19	SLC portion of Development (32.98%)		1,727	288		288		1,727	19
20									20
21									21
22	Current Year Purchases								22
23	SLC Direct - FFE								23
24	Furniture, nightstands, chests, headboards		11,273	1,127		1,127		1,127	24
25	Bearings, Seals, Shaft Sleeve for washer repalced		1,410	141		141		141	25
26	Little Giant Xtreme Ladder		550	55		55		55	26
27	Washer & Dryer Home 5		1,053	105		105		105	27
28	Gas Dryer Home 4		570	57		57		57	28
29	Urban sofa		1,247	125		125		125	29
30	Electric Table Can Opener		597	60		60		60	30
31	Total SLC Direct		16,699	1,670		1,670		1,670	31
32									32
33	REVERSE EVERYTHNG AND PICK UP BLDG IMPROVEMENTS ONLY		(340,347)	(41,214)		(41,214)		(102,907)	33
34	TOTAL (lines 1 thru 33)		$ 5,335,418	$ 265,187		$ 265,187	$	$ 3,562,952	34

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

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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	$ 213,473	$ 17,320	$ 17,320	$		$ 32,834	71
72	Current Year Purchases	24,825	2,539	2,539			2,539	72
73	Fully Depreciated Assets	176,230					176,230	73
74								74
75	TOTALS	$ 414,528	$ 19,859	$ 19,859	$		$ 211,603	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	client transportation	Dodge Gran Caravan 2008	2009	$ 37,733	$ 7,547	$ 7,547	$		$ 26,413	76
77	client transportation	Ford Supreme 2010	2010	47,856	9,571	9,571			33,499	77
78	client transportation	Ford Eldorado AeroTech	2011	57,746	11,549	11,549			28,873	78
79										79
80	TOTALS			$ 143,335	$ 28,667	$ 28,667	$		$ 88,785	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)	$ 6,107,955	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 313,713	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 313,713	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,863,340	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: Millbrook Real Estate

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. [X] 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:		N/A	03/01/2011	$ 78,242			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 78,242 **			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: ______ *

10. Effective dates of current rental agreement:
Beginning 03/2011
Ending 12/2021

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

	Fiscal Year Ending	Annual Rent
12.	06/2014	$ 38,833
13.	06/2015	$ 40,572
14.	06/2016	$ 42,311

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.

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] 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: 40
   - IN OTHER FACILITY:
   - COMMUNITY COLLEGE:
   - HOURS PER CNA:

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM: 80
   - 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	325	500		825
3	Classroom Wages (a)	4,554	7,316		11,870
4	Clinical Wages (b)	1,769	14,632		16,401
5	In-House Trainer Wages (c)	2,405	3,700		6,105
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$ 9,053	$ 26,148	$	$ 35,201
10	SUM OF line 9, col. 1 and 2 (e)	$ 35,201			

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	20
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	20
2. From other facilities (f)	
TOTAL TRAINED	40

(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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	N/A	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		# of prescrpts							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			$		$	$		$	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 Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2013 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,524,198	$	1
2	Cash-Patient Deposits	225,398		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 27,900)	3,421,764		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	255,671		5
6	Prepaid Insurance	251,596		6
7	Other Prepaid Expenses	6,552		7
8	Accounts Receivable (owners or related parties)	6,164		8
9	Other(specify): secrity deposits	25,467		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 7,716,810	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	4,605,485		12
13	Land	1,506,314		13
14	Buildings, at Historical Cost	11,128,793		14
15	Leasehold Improvements, at Historical Cost	7,998,496		15
16	Equipment, at Historical Cost	2,227,522		16
17	Accumulated Depreciation (book methods)	(14,055,072)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	16,940		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 13,428,478	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 21,145,288	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 568,209	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	226,420		28
29	Short-Term Notes Payable	287,022		29
30	Accrued Salaries Payable	814,815		30
31	Accrued Taxes Payable (excluding real estate taxes)	42,909		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	12,006		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	deferred income	55,125		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,006,506	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,406,817		39
40	Mortgage Payable	2,200,468		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)**	$ 5,607,285	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,613,791	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 13,531,497	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 21,145,288	$	48

*(See instructions.)

Facility Name & ID Number Iona Glos SLC # 0022996 **Report Period Beginning:** 07/01/2012 **Ending:** 06/30/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(205,141)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (205,141)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (205,141)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,694,159	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,694,159	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	2,000	10
11	CNA Training Reimbursements	33,827	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 35,827	23
	D. Non-Operating Revenue		
24	Contributions	396,937	24
25	Interest and Other Investment Income***	33,334	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 430,271	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28		9,364	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,364	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,169,621	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,072,799	31
32	Health Care	2,604,363	32
33	General Administration	1,936,129	33
	B. Capital Expense		
34	Ownership	412,711	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	348,760	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,374,762	40
41	**Income before Income Taxes (line 30 minus line 40)****	(205,141)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (205,141)	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 Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

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	1,804	2,100	$ 71,003	$ 33.81	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,135	11,355	302,138	26.61	3
4	Licensed Practical Nurses	13,177	15,105	357,956	23.70	4
5	CNAs & Orderlies					5
6	CNA Trainees	1,792	1,792	34,376	19.18	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,629	2,877	33,074	11.50	10
11	Social Service Workers					11
12	Dietician	3,771	4,473	45,723	10.22	12
13	Food Service Supervisor	1,771	2,089	38,021	18.20	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,508	4,044	50,710	12.54	15
16	Dishwashers					16
17	Maintenance Workers	7,051	7,051	148,111	21.01	17
18	Housekeepers	400	400	3,840	9.60	18
19	Laundry					19
20	Administrator	1,781	2,121	53,984	25.45	20
21	Assistant Administrator	1,561	1,786	57,283	32.07	21
22	Other Administrative	16,219	19,315	341,951	17.70	22
23	Office Manager	1,790	2,080	35,769	17.20	23
24	Clerical	1,733	2,095	24,905	11.89	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	11,343	13,195	209,692	15.89	28
29	Resident Services Coordinator	1,761	2,086	41,355	19.83	29
30	Habilitation Aides (DD Homes)	96,611	109,560	1,342,712	12.26	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	13,090	13,025	422,745	32.46	33
34	TOTAL (lines 1 - 33)	191,927	216,549	$ 3,615,348 *	$ 16.70	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	361	$ 19,059	1	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) psychologist	9	1,755	15	46
47	physician	monthly	24,000	15	47
48	dental and optometric	65	2,265	15	48
49	TOTAL (lines 35 - 48)	435	$ 47,079		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	415	17,307	10	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	415	$ 17,307		53

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2012 Ending: 06/30/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
see worksheet 9			$ 580,837
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 580,837

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
see worksheet 2		$ 105,157
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 105,157

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 201,470
Unemployment Compensation Insurance	25,431
FICA Taxes	264,241
Employee Health Insurance	290,613
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
other - pension plan	22,114
other - employee incentives	5,665
TOTAL (agree to Schedule V, line 22, col.8)	$ 809,534

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
NONE		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee		$
Advertising: Employee Recruitment		
Health Care Worker Background Check		6,992
(Indicate # of checks performed	37)	370
Patient Background Checks	6	60
subscriptions/publications		176
memberships dues		11,654
Less: Public Relations Expense		( )
Non-allowable advertising		( )
Yellow page advertising		( )
TOTAL (agree to Sch. V, line 20, col. 8)		$ 19,252

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ NONE
In-State Travel	NONE
Seminar Expense	NONE
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**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
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	NONE		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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. ________

(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? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **27,259** 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. $ **348,760**
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? **n/a**

(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. $ **n/a** Has any meal income been offset against related costs? ________ Indicate the amount. $ ________

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $ ________
c. What percent of all travel expense relates to transportation of nurses and patients? **n/a**
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: **Porte Brown, LLC**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.

Facilty Name & ID Number :Iona Gloss SLC/Ray Graham Association for People with Disabilities #0022996
Report Period Beginning: 07/01/12 Ending 06/30/13 Fiscal Year ended June 30, 2013
Fiscal Year ended June 30, 2013

WORKSHEET 1

RAY GRAHAM ASSOCIATION COSTS					SLC Allocation of…								
				Sum	RGA Adm	RGA P/R &	Sum Mngm	Direct	RGA Audit				Other
SCH V		RGA Admin	RGA P/R &	RGA Mngmt	Services	Developme	& General	Program	Figures			Adjust for	Non-Allow &
LINE REF	Line Item	Services	Developm	& General	29.88%	32.98%		Cost	SLC	Reclassed	Sum	nd Raising	Adjustment
	Salaries and related expenses:												
Sch XVIII	Salaries	1,314,902	90,623	1,405,525	392,858	29,887	422,745	3,192,603	3,615,348		3,615,348	(14,944)	
22	Unemployment	85,009	-	85,009	25,431	-	25,431	-	25,431		25,431	-	
22	FICA	91,936	6,750	98,686	27,470	2,226	29,696	235,658	265,354		265,354	(1,113)	
22	Health Insurance	111,353	7,039	118,393	33,262	2,322	35,584	256,145	291,729		291,729	(1,161)	
22	403B Plan Expense	73,922	-	73,922	22,114	-	22,114	-	22,114		22,114	-	
22	Insurance: Executive	-	-	-	-	-	-	-	-		-	-	
22	Employee Incentives	14,822	0	14,822	4,432	-	4,432	1,233	5,665		5,665	-	
22	Insurance: Workers' Comp	70,924	11,589	82,512	21,190	3,822	25,012	175,566	200,578		200,578	(1,911)	
22	Work Comp Out-of-Pocket	-	-	-	-	-	-	2,803	2,803		2,803	-	
22	Existing Staff Medical	-	-	-	-	-	-	45	45		45	-	
26	Insurance: D & O	7,425	-	7,425	2,219	-	2,219	-	2,219		2,219	-	
									-				
	Direct services:												
Sch XVIII	Clinical Consultants	-	-	-	-	-	-	47,079	47,079		47,079	-	
Sch XVIII	Temporary Workers	370	9,326	9,696	111	3,076	3,187	17,307	20,494		20,494	-	(3,076)
3	Client Wages - Janitorial	1,183	-	1,183	353	-	353	-	353		353	-	
10 & 13	Medical	-	-	-	-	-	-	53,949	53,949		53,949	-	
10	Adult Briefs	-	-	-	-	-	-	27,259	27,259		27,259	-	
11	Rehab & Educ Supplies	-	-	-	-	-	-	6,813	6,813		6,813	-	
3	Supplies	1,005	-	1,005	300	-	300	98,086	98,386		98,386	-	
11	Recreation	-	-	-	-	-	-	19,298	19,298		19,298	-	
6 & 21	Equipment Purchases	152	0	153	44	-	44	13,543	13,587		13,587	-	
6 & 21	Equipment Lease/Maint/Repair	28,117	4,075	32,192	8,401	1,344	9,745	18,787	28,532	(20,758)	7,774	(672)	
35	Equipment Lease				-				-	20,758	20,758	-	
3	In Kind Contributions	-	73,410	73,410	-	24,211	24,211	-	24,211		24,211	(24,211)	
14 & 25	Staff Travel	5,091	1,786	6,877	1,522	589	2,111	4,642	6,753		6,753	(295)	
14	Vehicle Fuel	6,953	1	6,953	2,078	-	2,078	31,842	33,920		33,920	-	
14	Vehicle Repairs & Maintenance	3	0	3	1	-	1	19,746	19,747		19,747	-	
14	Vehicle Inspections & Safety	-	-	-	-	-	-	357	357		357	-	
26	Vehicle Insurance	6	0	7	1	-	1	15,304	15,305		15,305	-	

35	Vehicle Leases	-	-	-	-	-	-	-	-	-	-	
14	Vehicle Licenses	0	0	0	-	-	-	70	70	70	-	
14	Contract Busing	-	-	-	-	-	-	-	-	-	-	
23	Conferences & Seminars	6,727	571	7,298	2,011	188	2,199	1,397	3,596	3,596	(94)	(390)
26	Insurance: Gen'l & Pro Liability	-	-	-	-	-	-	32,123	32,123	32,123	-	
21	Telephone	18,105	2,571	20,676	5,410	848	6,258	9,842	16,100	16,100	(424)	
21	Cell Phone	4,097	301	4,397	1,224	99	1,323	3,896	5,219	5,219	(50)	
	Program support:											
2	Food	-	-	-	-	-	-	341,878	341,878	341,878	-	
19	Payroll Service	50,475	-	50,475	15,068	-	15,068	-	15,068	15,068	-	
19	Audit	37,200	-	37,200	11,105	-	11,105	-	11,105	11,105	-	
19	Legal	74,419	-	74,419	22,257	-	22,257	-	22,257	22,257	-	(22,257)
19	Professional Services	10,670	143,415	154,085	3,191	47,298	50,489	-	50,489	50,489	-	(47,298)
21	Office Supplies & Equipment	8,396	1,452	9,848	2,509	479	2,988	6,172	9,160	9,160	(240)	
21	Training Materials	6,783	-	6,783	2,029	-	2,029	-	2,029	2,029	-	
21	Computer Equip & Supplies	6,379	-	6,379	1,905	-	1,905	-	1,905	1,905	-	
19	Software Maintenance	10,220	-	10,220	3,051	-	3,051	-	3,051	3,051	-	
	Occupancy:											
26	Insurance: Building	1,671	242	1,912	500	80	580	12,291	12,871	12,871	(40)	
3	Janitorial Contracts	-	-	-	-	-	-	78,960	78,960	78,960	-	
5	Utilities: Electric	7,461	1,011	8,472	2,229	334	2,563	55,470	58,033	58,033	(167)	
5	Utilities: Natural Gas	440	-	440	132	-	132	26,855	26,987	26,987	-	
5	Utilities: Water	-	-	-	-	-	-	39,156	39,156	39,156	-	
7	Utilities: Waste Removal	697	-	697	208	-	208	31,264	31,472	31,472	-	
6	Building & Grounds	1,322	9	1,331	394	3	397	14,279	14,676	14,676	(2)	
6	Fire, Safety & Security	376	-	376	112	-	112	12,347	12,459	12,459	-	
6	Maintenance Supplies	-	-	-	-	-	-	-	-	-	-	
6	Repairs and Maintenance	304	31	335	91	11	102	34,397	34,499	34,499	(6)	
34	Rent	242,461	35,189	277,650	72,440	11,605	84,045	-	84,045	84,045	(5,803)	
33	Real Estate Taxes	1,151	-	1,151	344	-	344	-	344	344	-	(344)
6	Damages	-	-	-	-	-	-	(1,007)	(1,007)	(1,007)	-	
	Other:											
21	Postage	6,973	3,451	10,424	2,084	1,138	3,222	1,398	4,620	4,620	(569)	
21	Printing	1,209	5,103	6,312	361	1,683	2,044	390	2,434	2,434	(842)	
20	Publications	225	664	889	67	219	286	-	286	286	(110)	
15 & 21	Certifications	56	-	56	17	-	17	675	692	692	-	
20	Recruitment	22,778	-	22,778	6,814	-	6,814	-	6,814	6,814	-	
20	Advertisements	-	1,656	1,656	-	546	546	-	546	546	(273)	

20	Marketing Materials	-	1,977	1,977	-	652	652	-	652		652	(326)	
20	Networking	-	54	54	-	18	18	-	18		18	(9)	
20	Memberships	37,454	2,801	40,255	11,192	924	12,116	-	12,116		12,116	(462)	
27	Agency Functions	7,867	143,399	151,266	2,341	47,301	49,642	-	49,642		49,642		(49,642)
27	Special Events	-	-	-	-	-	-	-	-		-	-	-
42	SLC Participation Fees	-	-	-	-	-	-	348,760	348,760		348,760	-	
27	Moving Expenses	-	-	-	-	-	-	-	-		-	-	-
27	Miscellaneous Expense	-	-	-	-	-	-	-	-		-	-	
32	Interest	-	-	-	-	-	-	-	-		-	-	
27	Bad Debts	10,000	-	10,000	2,985	-	2,985	-	2,985		2,985	-	(2,985)
27	Bank Charges	23,291	-	23,291	6,953	-	6,953	-	6,953		6,953	-	
27	Fines, Penalties & Late Fees	921	10	931	275	3	278	31	309		309		(309)
	Depreciation and amortization:												
30	Depn Expense - Vehicles	-	-	-	-	-	-	28,667	28,667		28,667	-	
30	Depn Expense - Bldgs	1,469	-	1,469	439	-	439	92,048	92,487		92,487	-	(439)
30	Depn Expense - Bldg Improv	-	-	-	-	-	-	173,198	173,198		173,198	-	(59)
30	Depn Expense - F,F & E	22,627	873	23,499	6,758	288	7,046	12,813	19,859		19,859	-	
30	Amort - Leasehold Improvemer	3,537	697	4,234	1,056	230	1,286	-	1,286		1,286	-	(1,286)
	TOTAL EXPENSES	2,440,936	550,076	2,991,012	729,339	181,415	910,776	5,595,435	6,506,211	-	6,506,198	(53,724)	(128,085)

Notes: (a) Allocation based on percentage of total direct expenses.

Total
3,600,404
25,431
264,241
290,568
22,114
-
5,665
198,667
2,803
45
2,219
47,079
17,418
353
53,949
27,259
6,813
98,386
19,298
13,587
7,102
20,758
-
6,458
33,920
19,747
357
15,305

-
70
-
3,112
32,123
15,676
5,169

341,878
15,068
11,105
-
3,191
8,920
2,029
1,905
3,051

12,831
78,960
57,866
26,987
39,156
31,472
14,674
12,459
-
34,493
78,242
-
(1,007)

4,051
1,592
176
692
6,814
273

326
9
11,654
-
-
348,760
-
-
-
-
6,953
-
-
-
28,667
92,048
173,139
19,858
-
6,324,387

Worksheet 3
Detail of Other Expense on Schedule V. line 27

Management & General

allocated from Administration

bank fees			23,291	
			23,291	
	SLC alloc	29.85%		6,953
Total Expense				6,953

Facilty Name & ID Number :Iona Gloss SLC/Ray Graham Association for People with Disabilities #0022996
Report Period Beginning: 07/01/12 Ending 06/30/13 Fiscal Year ended June 30, 2013

Worksheet 6
Detail for schedule IX, part A - Interest Expense, Working Capital

col 1 Name of Lender	col 2 Related ?	col 3 Purpose	col 4 Monthly Payment	col 5 Date of Note	col 6 Original Amount	col 7 Bal	col 8 Maturity Date	col 9 Rate (4 digits)	col 10 Int Exp
from admin - Short Term/Working Capital									
Beverly Bank	no	operating	n/a		0			4.0000	0
line of credit		funds			0			4.0000	0
Total RGA Management & General (Administration)					0	0			0
SLC allocation =	0.00%				0	0			0

Facilty Name & ID Number :Iona Gloss SLC/Ray Graham Association for People with Disabilities #0022996
Report Period Beginning: 07/01/12 Ending 06/30/13 Fiscal Year ended June 30, 2013

Worksheet 8

Detail for Schedule XII part B. Equipment Rental - Excluding Transportation and Fixed Equipment

Movable Equipment Description						SLC %	SLC Cost
SLC							
postage system							2,033
copier							12,092
	Total SLC					100%	14,125
901 Building							
copier	16,189						
water cooler	0						
postage system	9,745						
	25,934						
		Administration	21.31%	5,528		29.88%	1,652
		Employee Services	19.59%	5,080		29.92%	1,520
		Pub Rel & Develop	12.14%	3,149		32.98%	1,039
		less 50%					(519)
		Finance	38.00%	9,855		29.85%	2,942
							6,633
Total Expense							20,758

Facilty Name & ID Number :Iona Gloss SLC/Ray Graham Association for People with Disabilities #0022996
Report Period Beginning: 07/01/12 Ending 06/30/13 Fiscal Year ended June 30, 2013
Worksheet 9

Detail for Schedule XIX. part A. Administrative Salaries

Name		Function	% Ownership		SLC Amount
Direct Staff					
	Blum, Alan	SLC Director			42,572
	Noreiga, Lynette	Assistant Director			57,283
	Castro, Amy	System Administrator			24,254
	Hickey-Scaccia, Marianne	Administrator			53,984
	Badalamenti, Salvatore	Coordinator			39,163
	Harmon, Shanta	Coordinator			31,944
	Jones, Anthony	Coordinator			31,722
	Kachhawala, Zainab	Coordinator			35,172
	Patel, Janki	Coordinator			33,729
	Bruce, Pamela	Home Manager			34,835
	Kerechek, James	Home Manager			28,744
	Patel, Ushma	Home Manager			41,188
	Smith, Chitashia (Resigned)	Home Manager			(1,372)
	total SLC direct		100%		453,218
Management and General Allocated					
Administrators					
	Carmody, Kathleen	Chief of Staff		143,307	
	Zoeller, Kimberly	President		174,726	
	Alfano, Giuliana	QHSP		2,000	
	Kern, Danny	QHSP		400	
	Mertes, Casadre	QHSP		2,000	
	Pape, Sarah	QHSP Manager		2,000	
	Whitworth, Erin	System Administrator		2,000	
		Allocated thru Building Maintenance		642	
	SLC allocation		30%	327,075	97,732
Development					
	Nagle, Lorraine	Chief Development Officer		4,953	
	Baker, Julia	Community Relations/Special Events Coord (Resigned)		6,216	

Glenn, Mary B	Corp Relations & Major Gifts Facilitator		45,399	
Glenn, Siobhan	Advancement/Marketing Coordinator (Resigned)		33,973	
	Allocated thru Building Maintenance		82	
SLC allocation		33%	90,623	29,887

Total Administrative Salaries reported on Schedule 5, Line 17, Column 1 580,837

Facilty Name & ID Number :Iona Gloss SLC/Ray Graham Association for People with Disabilities #0022996
Report Period Beginning: 07/01/12 Ending 06/30/13 Fiscal Year ended June 30, 2013

Ray Graham Association
Board of Directors
FY 2013

Officer	Residence	Business
Chairperson		
Mary Kay Rizzolo Mann Executive/Nominating Committee Quality enhancement Committee	1713 W. Schubert Avenue Chicago, IL 60614 (773) 868-0263 Mrizzo3@uic.edu	Clinical Associate Professor University of IL at Chicago Associate Director of Institute on Disability and Human Development
Vice-Chairperson		
Michael Komoll Executive/Nominating Committee Human Rights Committee	3420 Richnee Lane Rolling Meadows, IL 60008 michael.komoll@cna.com	Assistant Vice President - Major Litigation C.N.A Insurance 333 S. Wabash, 27S/29-1 Chicago, IL 60685 (312) 822-2816
Immediate Past Chairperson		
Laura Sakas Executive/Nominating Committee Human Rights Committee	4047 Wolf Road Western Springs, IL 60558 (708) 784-1505 lnsakas@yahoo.com	Managing Attorney Office of State Guardian Division of IL Guardianship and Advocacy (312) 793-5332 (708) 415-0972
Secretary/Treasurer		
Lou Leonardi III Executive/Nominating Committee Human Rights Committee	609 Ashland River Forest, IL 60305 lleonardi@thebeverkybank.com	The Beverly Bank 10258 S. Western Avenue Chicago, IL 60643 (773) 239-2265
Members-at-Large		
Lee Jorwic Development Committee	375 S. Kenilworth Elmhurst, IL 60126 (630) 240-0967	President Klatt-Jorwic & Associates 127 W. Wrightwood

	ljorwic@klattjorwic.com	Elmhurst, IL 60126 (630) 833-4193
Members-at-Large Deanna Wilkins - C.I.A.O Quality Committee	Deanna@wilkinsconstruction.com deanwilkins@comcast.net	York Township Assessor's Office 1502 South Meyers Road Lombard, IL 60148 (630) 627-3354 (630) 627-3022 fax
Directors Neville Bilimoria Quality Committee	2515 Chestnut Ave. Glenview, IL 60026 (847) 486-1868 nmbilimoria@duanemorris.com	Attorney Duane Morris 190 S. LaSalle St. #3700 Chicago, IL 60603 (312) 499-6758
Directors Joseph Derezinski	236 S. Bodin St. Hinsdale, IL 60521 (630) 734-3417 ljderezinski@ameritech.net	Sr. Vice President Harris Bank 111 W. Monroe St. 5C Chicago, IL 60603
Directors Jane Kaufman Human Rights Committee	188 East Park Elmhurst, IL 60126 (630) 947-5879 janekaufman4@gmail.com	Office Assistant
Directors Chris Nybo	444 Mitchell Elmhurst, IL 60126 (630) 617-5334 (312) 307-8270 Chris.nybo@gmail.com	Vedder Price P.C. 222 North LaSalle Street Chicago, IL 60601 (312) 609-7500
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	Jeff.Park@sxc.com	Lisle, IL 60532 (630) 577-3206
Directors Richard Phelan Finance Committee	242 E. 8th Street Hinsdale, IL 60521 richard_phelan@ml.com	Investment Advisor Merryl Lynch 2021 Spring Rd. Ste 700 Oak Brook, IL 60523 (630) 954-6310
Directors Jonathan Phillips Finance Committee	792 Chatham Avenue Elmhurst, IL 60126 (312) 276-5180 jp@healthcaregrowth.com	Managing Director Healthcare Growth Partners 792 Chatham Avenue Elmhurst, IL 60126 (630) 530-4420
Directors Mary Alice Povolny, Ph.D	633 Monroe Street River Forest, IL 60305 (708) 366-6963 (708) 790-2371 m.povolny@att.net	Clinicasl Psychologist 188 Industrial Park, Ste 132 Elmhurst, IL 60126 (630) 415-0780
Directors Robert F. Spahn, Jr. CLU, ChFc Golf Committee	933 Kent Elmhurst, IL 60126 robert.spahnjr@nmfn.com	Northwestern Mutual Financial Representative 377 E. Butterfield Rd., Suite 325 Lombard, IL 60148 (630) 458-7019
Directors Chris Schneider Finance Committee	5071 Priairie Sage Rd Naperville, IL 60564 cljdschneider@aol.com	Vice President Blackrock (847) 338-5120