FOR BHF USE

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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: 0052506

Facility Name: Island City Rehab Center

Address: 555 West Kahler (Number) Wilmington (City) 60481 (Zip Code)

County: Will

Telephone Number: (815) 476-7931 **Fax #** (815) 476-7939

HFS ID Number:

Date of Initial License for Current Owners: 12/6/2006

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
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 01/01/13 to 12/31/13 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)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Cary C. Buxbaum, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	80	Skilled (SNF)	80	29,200	1
2		Skilled Pediatric (SNF/PED)			2
3	91	Intermediate (ICF)	91	33,215	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	171	TOTALS	171	62,415	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,537	130	4,737	6,404	8
9	SNF/PED					9
10	ICF	46,801	3,521	2,409	52,731	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,338	3,651	7,146	59,135	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.74%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 12/06/06

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/06/06 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 80 and days of care provided 3,784

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	94,330	215,364	11,525	321,219		321,219	3,582	324,801			1
2	Food Purchase		364,848		364,848		364,848	(224)	364,624			2
3	Housekeeping	219,593	10,104		229,697		229,697		229,697			3
4	Laundry	60,856	11,863		72,719		72,719		72,719			4
5	Heat and Other Utilities			132,451	132,451		132,451	(3,717)	128,734			5
6	Maintenance	62,630	105,249	113,000	280,879		280,879	5,606	286,485			6
7	Other (specify):*							769	769			7
8	TOTAL General Services	437,409	707,428	256,976	1,401,813		1,401,813	6,016	1,407,829			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	1,995,536	103,558	16,008	2,115,102		2,115,102	6,942	2,122,044			10
10a	Therapy	94,170	130	37,432	131,732		131,732		131,732			10a
11	Activities	229,199	10,408		239,607		239,607		239,607			11
12	Social Services	208,360		1,657	210,017		210,017		210,017			12
13	CNA Training											13
14	Program Transportation							1,017	1,017			14
15	Other (specify):*							2,298	2,298			15
16	TOTAL Health Care and Programs	2,527,265	114,096	76,097	2,717,458		2,717,458	10,257	2,727,715			16
	C. General Administration											
17	Administrative	79,705			79,705		79,705	18,718	98,423			17
18	Directors Fees											18
19	Professional Services			203,137	203,137		203,137	(43,665)	159,472			19
20	Dues, Fees, Subscriptions & Promotions			22,383	22,383		22,383	657	23,040			20
21	Clerical & General Office Expenses	285,653	21,267	171,041	477,961		477,961	(105,084)	372,877			21
22	Employee Benefits & Payroll Taxes			778,296	778,296		778,296		778,296			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,371	4,371		4,371	342	4,713			24
25	Other Admin. Staff Transportation			12,874	12,874		12,874	1,915	14,789			25
26	Insurance-Prop.Liab.Malpractice			175,458	175,458		175,458	636	176,094			26
27	Other (specify):*							10,990	10,990			27
28	TOTAL General Administration	365,358	21,267	1,367,560	1,754,185		1,754,185	(115,491)	1,638,694			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,330,032	842,791	1,700,633	5,873,456		5,873,456	(99,218)	5,774,238			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Island City Rehab Center #0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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			3,516	3,516		3,516	167,300	170,816			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			277,171	277,171		277,171	1,693	278,864			32
33	Real Estate Taxes			94,400	94,400		94,400	1,588	95,988			33
34	Rent-Facility & Grounds			243,000	243,000		243,000	(243,000)				34
35	Rent-Equipment & Vehicles			1,325	1,325		1,325	1,650	2,975			35
36	Other (specify):*											36
37	**TOTAL Ownership**			619,412	619,412		619,412	(70,769)	548,643			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	341,329	209,433	166,671	717,433		717,433	(27,210)	690,223			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			428,278	428,278		428,278		428,278			42
43	Other (specify):*			257,694	257,694		257,694	(257,694)	0			43
44	**TOTAL Special Cost Centers**	341,329	209,433	852,643	1,403,405		1,403,405	(284,904)	1,118,501			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,671,361	1,052,224	3,172,688	7,896,273		7,896,273	(454,890)	7,441,383			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	(4,119)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	165,310	30		9
10	Interest and Other Investment Income	(97)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(224)	02		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	(15,307)	21		18
19	Entertainment	(2,864)	21		19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(89,000)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(529,698)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (476,498)		$	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)	21,608		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 21,608		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (454,890)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Island City Rehab Center

ID# 0052506

Report Period Beginning: 01/01/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non Allowable Expense	$ (239,100)	43	1
2	Marketing	(18,594)	43	2
3	Bank Charges	(15,936)	21	3
4	Misc Income	(10,771)	21	4
5	Sequestration	(8,319)	21	5
6	Additional R&M	3,022	06	6
7	Building Rent	(240,000)	34	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**	(529,698)		49

Island City Rehab Center

ID# 0052506

Report Period Beginning: 01/01/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Island City Rehab Center # 0052506 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				3,582								3,582	1
2	Food Purchase	(224)											(224)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(4,119)		402									(3,717)	5
6	Maintenance	3,022		705	1,879								5,606	6
7	Other (specify):*			60	709								769	7
8	**TOTAL General Services**	(1,321)		1,167	6,170								6,016	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				6,942								6,942	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation				1,017								1,017	14
15	Other (specify):*				2,298								2,298	15
16	**TOTAL Health Care and Programs**				10,257								10,257	16
	C. General Administration													
17	Administrative			9,539	9,179								18,718	17
18	Directors Fees													18
19	Professional Services			(37,585)	(4,855)	119	(1,344)						(43,665)	19
20	Fees, Subscriptions & Promotions	(500)		268	883	6							657	20
21	Clerical & General Office Expenses	(142,197)		30,061	7,000	52							(105,084)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			111	231								342	24
25	Other Admin. Staff Transportation			1,029	886								1,915	25
26	Insurance-Prop.Liab.Malpractice			528	108								636	26
27	Other (specify):*			8,043	2,947								10,990	27
28	**TOTAL General Administration**	(142,697)		11,994	16,379	177	(1,344)						(115,491)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(144,018)		13,161	32,806	177	(1,344)						(99,218)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Island City Rehab Center # 0052506 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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	165,310		645		1,345							167,300	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(97)		531		1,259							1,693	32
33	Real Estate Taxes					1,588							1,588	33
34	Rent-Facility & Grounds	(240,000)		1,658		(4,658)							(243,000)	34
35	Rent-Equipment & Vehicles			693	957								1,650	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(74,787)		3,527	957	(466)							(70,769)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(27,210)					(27,210)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(257,694)											(257,694)	43
44	**TOTAL Special Cost Centers**	(257,694)						(27,210)					(284,904)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(476,498)		16,688	33,763	(289)	(1,344)	(27,210)					(454,890)	45

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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
See Pg 6-Supp		See Pg 6-Supp		See Pg 6-Supp		

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 [X] 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			$			$	$	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.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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. [X] 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)	
15	V	5	UTILITIES	$	YAM MANAGEMENT, LLC	100.00%	$ 402	$ 402	15
16	V	6	REPAIRS & MAINTENANCE		YAM MANAGEMENT, LLC	100.00%	705	705	16
17	V	7	EMP. BEN.-GEN. SERV.		YAM MANAGEMENT, LLC	100.00%	60	60	17
18	V	17	ADMINISTRATIVE		YAM MANAGEMENT, LLC	100.00%	9,539	9,539	18
19	V	19	PROFESSIONAL FEES		YAM MANAGEMENT, LLC	100.00%	1,722	1,722	19
20	V	20	FEES, SUBSCRIPTIONS		YAM MANAGEMENT, LLC	100.00%	268	268	20
21	V	21	CLERICAL & GENERAL		YAM MANAGEMENT, LLC	100.00%	30,061	30,061	21
22	V	24	SEMINARS		YAM MANAGEMENT, LLC	100.00%	111	111	22
23	V	25	AUTO AND TRAVEL		YAM MANAGEMENT, LLC	100.00%	1,029	1,029	23
24	V	26	INSURANCE		YAM MANAGEMENT, LLC	100.00%	528	528	24
25	V	27	EMP. BEN.-GEN. ADMIN.		YAM MANAGEMENT, LLC	100.00%	8,043	8,043	25
26	V	30	DEPRECIATION		YAM MANAGEMENT, LLC	100.00%	645	645	26
27	V	32	INTEREST		YAM MANAGEMENT, LLC	100.00%	531	531	27
28	V	33	REAL ESTATE TAX		YAM MANAGEMENT, LLC	100.00%			28
29	V	34	RENT		YAM MANAGEMENT, LLC	100.00%	4,658	4,658	29
30	V	35	AUTO RENTAL		YAM MANAGEMENT, LLC	100.00%	693	693	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V	19	BOOKKEEPING FEES	33,307	YAM MANAGEMENT, LLC	100.00%		(33,307)	35
36	V	19	ACCOUNTING	6,000	YAM MANAGEMENT, LLC	100.00%		(6,000)	36
37	V	34	RENT	3,000	YAM MANAGEMENT, LLC	100.00%		(3,000)	37
38	V								38
39	Total			$ 42,307			$ 58,995	$ * 16,688	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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. [X] 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)	
15	V	1	DIETARY	$	YAM CONSULTING, LLC	100.00%	$ 4,282	$ 4,282	15
16	V	7	EMP. BEN. GEN. SERV.		YAM CONSULTING, LLC	100.00%	709	709	16
17	V	10	NURSING SALARY		YAM CONSULTING, LLC	100.00%	16,542	16,542	17
18	V	14	PROGRAM TRANSPORTATION		YAM CONSULTING, LLC	100.00%	1,017	1,017	18
19	V	15	EMP. BEN. HEALTHCARE		YAM CONSULTING, LLC	100.00%	2,298	2,298	19
20	V	17	ADMINISTRATIVE		YAM CONSULTING, LLC	100.00%	9,179	9,179	20
21	V	19	PROFESSIONAL FEES		YAM CONSULTING, LLC	100.00%	497	497	21
22	V	20	FEES, SUBSCRIPTIONS		YAM CONSULTING, LLC	100.00%	883	883	22
23	V	21	CLERICAL & GENERAL		YAM CONSULTING, LLC	100.00%	7,000	7,000	23
24	V	24	SEMINARS		YAM CONSULTING, LLC	100.00%	231	231	24
25	V	25	AUTO AND TRAVEL		YAM CONSULTING, LLC	100.00%	886	886	25
26	V	27	EMP. BEN.-GEN. ADMIN.		YAM CONSULTING, LLC	100.00%	2,947	2,947	26
27	V	26	INSURANCE		YAM CONSULTING, LLC	100.00%	108	108	27
28	V	35	AUTO RENTAL		YAM CONSULTING, LLC	100.00%	957	957	28
29	V	6	REPAIRS AND MAINTENANCE SALARY		YAM CONSULTING, LLC	100.00%	1,879	1,879	29
30	V								30
31	V								31
32	V								32
33	V	1	DIETICIAN CONSULTING	700	YAM CONSULTING, LLC	100.00%		(700)	33
34	V	10	NURSE CONSULTING	9,600	YAM CONSULTING, LLC	100.00%		(9,600)	34
35	V	19	DATA PROCESSING	5,352	YAM CONSULTING, LLC	100.00%		(5,352)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 15,652			$ 49,415	$ * 33,763	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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. [X] 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)	
15	V	19	PROFESSIONAL FEES	$	8131 N. MONTICELLO, LLC	100.00%	$ 119	$ 119	15
16	V	20	DUES & SUBSCRIPTIONS		8131 N. MONTICELLO, LLC		6	6	16
17	V	21	OFFICE EXPENSE		8131 N. MONTICELLO, LLC		52	52	17
18	V	30	DEPRECIATION		8131 N. MONTICELLO, LLC		1,345	1,345	18
19	V	32	INTEREST EXPENSE		8131 N. MONTICELLO, LLC		1,259	1,259	19
20	V	33	REAL ESTATE TAXES		8131 N. MONTICELLO, LLC		1,588	1,588	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	4,658	8131 N. MONTICELLO, LLC			(4,658)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,658			$ 4,369	$ * (289)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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. [X] 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)	
15	V	19	Payroll Services	$ 9,601	ProPay HR LLC	66.67%	$ 8,257	$ (1,344)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,601			$ 8,257	$ * (1,344)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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. [X] 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)	
15	V	39	THERAPY SERVICES	$ 170,061	RENEWAL REHAB	100.00%	$ 142,851	$ (27,210)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 170,061			$ 142,851	$ * (27,210)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	Morris Esformes	16.6700%	BERKSHIRE NURSING & REHAB CENTER,LLC	FOREST PARK	YAM MANAGEMENT	SKOKIE	MANAGEMENT CO.	1
2	The Rajchenbach Family Trust	16.6700%	CONCORD NURSING AND REHABILITATION CENTER,LLC	OAK LAWN	YAM CONSULTING	SKOKIE	CONSULTING CO.	2
3	Rita Lipshitz	16.6600%	EVENSTON NURSING & REHAB	EVANSTON	8131 N. MONTICELLO	SKOKIE	HOME OFFICE, BUILDING C	3
4	Delcaration of Trust Yosef Meystel	24.0000%	EXCEPTIONAL CARE, LLC	BURBANK	PROPAY	EVANSTON	PAYROLL SERVICES	4
5	David A. Berkowitz Revocable Trust	24.0000%	HIGHLAND PARK NURSING AND REHAB CENTER, LLC	HIGHWOOD	RENEWAL REHAB	SKOKIE	THERAPY SERVICES	5
6	Steven Turofsky	1.0000%	INTERNATIONAL NURSING & REHAB CENTER,LLC	CHICAGO				6
7	Fredrick S. Frankel	1.0000%	LITCHFIELD CARE CENTER,LLC	LITCHFIELD				7
8			NORTH CHURCH NURSING & REHAB,LLC	JACKSONVILLE				8
9			PLAZA NURSING AND REHAB CENTER,LLC	MIDLOTHIAN				9
10			PLUM GROVE NURSING AND REHAB,LLC	PALATINE				10
11			RIVIERA CARE CENTER,LLC	CHICAGO HEIGHTS				11
12			SPRINGFIELD CARE CENTER,LLC	SPRINGFIELD				12
13			THE ARBORS AT MICHIGAN CITY	MICHIGAN CITY,IN				13
14			THE COPPERAS HOLLOW	CALDWELL, TX				14
15			DOLTON NURSING AND REHAB	DOLTON				15
16			LINCOLN REHAB	DECATUR				16
17			RIVERWOOD REHAB	EAST MOLINE				17
18			RIVER CROSSING REHAB	GALESBURG				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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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								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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	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 Reference	
						Hours	Percent	Description	Amount		
1	Yosef Meystel	Relative	Administrative	0.00%	See Attached	1	2.50%		$		1
2	Jay Meystel	Relative	Administrative	0.00%	See Attached	0.5	1.25%	Alloc Salary	1,562	17-7	2
3	Joel Meystel	Relative	Administrative	0.00%	See Attached	0.5	2.50%	Alloc Salary	641	17-7	3
4	Cynthia Meystel	Relative	Clerical	0.00%	See Attached	0.1	3.03%	Alloc Salary	470	21-7	4
5	Shimon Meystel	Relative	Clerical	0.00%	See Attached	1	2.50%	Alloc Salary	222	21-7	5
6	David Berkowitz	Relative	Administrative	0.00%	See Attached	1	2.50%				6
7	Fred Frakel	Owner	Administrative	1.00%	See Attached	1	2.50%	Alloc Salary	3,918	17-7	7
8	Steve Turofsky	Owner	Administrative	1.00%	See Attached	1	2.50%	Alloc Salary	3,418	17-7	8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 10,231		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [X]

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						$	$		$	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [X] NO [ ]

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

Name of Related Organization: YAM MANAGEMENT, LLC
Street Address: 8131 N. MONTICELLO
City / State / Zip Code: SKOKIE, ILLINOIS 60076
Phone Number: (847) 673-6767
Fax Number: (847) 673-6768

	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	5	UTILITIES	AVAIL. BED DAYS	806,222	20	$ 15,532	$	20,862	$ 402	1
2	6	REPAIRS & MAINTENANCE	AVAIL. BED DAYS	806,222	20	27,235	10,706	20,862	705	2
3	7	EMP. BEN.-GEN. SERV.	AVAIL. BED DAYS	806,222	20	2,325		20,862	60	3
4	17	ADMINISTRATIVE	AVAIL. BED DAYS	806,222	20	368,628	368,628	20,862	9,539	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	806,222	20	66,554		20,862	1,722	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	806,222	20	10,341		20,862	268	6
7	21	CLERICAL & GENERAL	AVAIL. BED DAYS	806,222	20	1,161,730	1,062,779	20,862	30,061	7
8	24	SEMINARS	AVAIL. BED DAYS	806,222	20	4,271		20,862	111	8
9	25	AUTO AND TRAVEL	AVAIL. BED DAYS	806,222	20	39,751		20,862	1,029	9
10	26	INSURANCE	AVAIL. BED DAYS	806,222	20	20,417		20,862	528	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	806,222	20	310,817		20,862	8,043	11
12	30	DEPRECIATION	AVAIL. BED DAYS	806,222	20	24,916		20,862	645	12
13	32	INTEREST	AVAIL. BED DAYS	806,222	20	20,530		20,862	531	13
14	33	REAL ESTATE TAX	AVAIL. BED DAYS	806,222	20			20,862		14
15	34	RENT	AVAIL. BED DAYS	806,222	20	180,000		20,862	4,658	15
16	35	AUTO RENTAL	AVAIL. BED DAYS	806,222	20	26,797		20,862	693	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,279,844	$ 1,442,113		$ 58,995	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [X] NO [ ]

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

Name of Related Organization: YAM CONSULTING, LLC
Street Address: 8131 N. MONTICELLO
City / State / Zip Code: SKOKIE, ILLINOIS 60076
Phone Number: (847) 673-6767
Fax Number: (847) 673-6768

	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	1	DIETARY	AVAIL. BED DAYS	806,222	20	$ 165,484	$ 152,992	20,862	$ 4,282	1
2	7	EMP. BEN. GEN. SERV.	AVAIL. BED DAYS	806,222	20	27,395		20,862	709	2
3	10	NURSING SALARY	AVAIL. BED DAYS	806,222	20	639,288	639,288	20,862	16,542	3
4	14	PROGRAM TRANSPORTATIO	AVAIL. BED DAYS	806,222	20	39,307		20,862	1,017	4
5	15	EMP. BEN. HEALTHCARE	AVAIL. BED DAYS	806,222	20	88,801		20,862	2,298	5
6	17	ADMINISTRATIVE	AVAIL. BED DAYS	806,222	20	354,711	354,711	20,862	9,179	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	806,222	20	19,212		20,862	497	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	806,222	20	34,122		20,862	883	8
9	21	CLERICAL & GENERAL	AVAIL. BED DAYS	806,222	20	270,517	258,772	20,862	7,000	9
10	24	SEMINARS	AVAIL. BED DAYS	806,222	20	8,935		20,862	231	10
11	25	AUTO AND TRAVEL	AVAIL. BED DAYS	806,222	20	34,250		20,862	886	11
12	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	806,222	20	113,873		20,862	2,947	12
13	26	INSURANCE	AVAIL. BED DAYS	806,222	20	4,192		20,862	108	13
14	35	AUTO RENTAL	AVAIL. BED DAYS	806,222	20	36,968		20,862	957	14
15	6	REPAIRS AND MAINTENANCE	AVAIL. BED DAYS	806,222	20	72,622	72,622	20,862	1,879	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,909,677	$ 1,478,385		$ 49,415	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [X] NO [ ]

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

Name of Related Organization: 8131 N. MONTICELLO, LLC
Street Address: 8131 N. MONTICELLO
City / State / Zip Code: SKOKIE, ILLINOIS 60076
Phone Number: (847) 673-6767
Fax Number: (847) 673-6768

	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	19	PROFESSIONAL FEES	AVAIL. BED DAYS	806,222	20	$ 4,605	$	37,960	$ 119	1
2	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	806,222	20	250		37,960	6	2
3	21	OFFICE EXPENSE	AVAIL. BED DAYS	806,222	20	2,000		37,960	52	3
4	30	DEPRECIATION	AVAIL. BED DAYS	806,222	20	51,991		37,960	1,345	4
5	32	INTEREST EXPENSE	AVAIL. BED DAYS	806,222	20	48,653		37,960	1,259	5
6	33	REAL ESTATE TAXES	AVAIL. BED DAYS	806,222	20	61,377		37,960	1,588	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					$ 168,876	$		$ 4,369	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [X] NO [ ]

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

Name of Related Organization: ProPay HR, LLC
Street Address: 2201 W. MAIN ST
City / State / Zip Code: EVANSTON, ILLINOIS 60202
Phone Number: (847) 905- 3268
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	19	Payroll Services	Direct			$	$		$ 8,257	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					$	$		$ 8,257	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 [X] NO [ ]

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

Name of Related Organization: RENEWAL REHAB
Street Address: 8131 N. MONTICELLO
City / State / Zip Code: SKOKIE, ILLINOIS 60076
Phone Number: (847) 673-6767
Fax Number: (847) 673- 6768

	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	39	THERAPY SERVICES	DIRECT			$	$		$ 142,851	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					$	$		$ 142,851	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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						$	$		$	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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						$	$		$	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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						$	$		$	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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						$	$		$	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	Auto Loan		X					39,857				6
7	The Private Bank		X	Line of Credit				891,527			3,281	7
8												8
9	TOTAL Facility Related						$	$ 931,384			$ 3,281	9
	B. Non-Facility Related*											
10	Interest- Insurance		X								913	10
11	Interest Expense		X								272,977	11
12	Allocated from 8131 N. Monticello		X								1,259	12
13	See Supplemental Schedule										434	13
14	TOTAL Non-Facility Related						$	$			$ 275,583	14
15	TOTALS (line 9+line14)						$	$ 931,384			$ 278,864	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15	Interest Income		X				$	$			$ (97)	15
16	Allocated from YAM Management		X								531	16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										434	20

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

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 44,834	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.)		$ 140,822	2
3. Under or (over) accrual (line 2 minus line 1).		$ 95,988	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.		$ 95,988	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	133,468	8
	2009	118,787	9
	2010	121,488	10
	2011	126,617	11
	2012	139,234	12

Allocated from 8131 N. Monticello = $1,588

Beginning accrual adjusted; Facility did not accrue for 2013 taxes

	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Island City Rehab Center COUNTY Will

FACILITY IDPH LICENSE NUMBER 0052506

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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.	03-17-36-300-010-0000	Long Term Care Facility	$ 139,234.42	$ 139,234.42
2.	10-23-325-045-0000	Allocated from 8131 N. Monticello	$ 70,666.20	$ 1,588.21
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 209,900.62	$ 140,822.63

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? X 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Island City Rehab Center COUNTY Will

FACILITY IDPH LICENSE NUMBER 0052506

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236 - 1111 FAX #: (847) 236 - 1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(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 & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,500 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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 [X] (b) Rent equipment from a Related Organization. [X] (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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Allocated from 8131 N. Monticello			$ 2,303	1
2	Facility	40,500	2006	145,000	2
3	TOTALS	40,500		$ 147,303	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	171		1993	1974	$ 2,363,000	$	35	$ 67,514	$ 67,514	$ 1,413,184	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	55,674		20			55,674	9
10	Various			1994	144,492		20	7,225	7,225	144,492	10
11	Various			1995	126,250		20	6,313	6,313	119,938	11
12	Various			1996	94,458		20	4,723	4,723	85,012	12
13	Various			1997	13,974		20	699	699	11,878	13
14	Various			1998	13,694		20	685	685	10,955	14
15	Various			1999	29,626		20	1,481	1,481	22,220	15
16	Various			2000	71,797		20	3,590	3,590	50,258	16
17	Various			2001	4,657		20	233	233	3,027	17
18	Various			2002	1,466		20	73	73	880	18
19	Various			2003	67,271		20	3,364	3,364	36,999	19
20	Various			2004	60,965		20	3,048	3,048	30,483	20
21	Various			2005	26,783		20	1,339	1,339	12,052	21
22	Various			2006	30,982		20	1,549	1,549	12,393	22
23	Various			2007	34,801		20	1,740	1,740	12,180	23
24	Various			2009	7,900		20	395	395	1,975	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		28,790	1,473		1,057	(416)	3,414	68
69	Financial Statement Depreciation			3,516			(3,516)		69
70	TOTAL (lines 4 thru 69)		$ 3,176,580	$ 4,989		$ 105,027	$ 100,038	$ 2,027,013	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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		$ 3,176,580	$ 4,989		$ 105,027	$ 100,038	$ 2,027,013	1
2	Security System-New Camera And Installation	2013	14,787		20	739	739	739	2
3	Installation Of Cat5E Cable For Data And Voice	2013	11,195		20	560	560	560	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	TOTAL (lines 1 thru 33)		$ 3,202,562	$ 4,989		$ 106,326	$ 101,337	$ 2,028,312	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 12B, Carried Forward		$ 3,202,562	$ 4,989		$ 106,326	$ 101,337	$ 2,028,312	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,202,562	$ 4,989		$ 106,326	$ 101,337	$ 2,028,312	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 12C, Carried Forward		$ 3,202,562	$ 4,989		$ 106,326	$ 101,337	$ 2,028,312	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,202,562	$ 4,989		$ 106,326	$ 101,337	$ 2,028,312	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 12D, Carried Forward		$ 3,202,562	$ 4,989		$ 106,326	$ 101,337	$ 2,028,312	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,202,562	$ 4,989		$ 106,326	$ 101,337	$ 2,028,312	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	Building Company Information		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$	$		$	$	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 8131 N. Monticello	2010	17,894	532	35	459	(73)	1,587	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from YAM Management	2010	852	85	20	85		279	9
10	Allocated from YAM Management	2012	538	36	20	36		54	10
11	Allocated from YAM Management	2013	96	6	20	6		6	11
12	Allocated from 8131 N. Monticello	2010	8,016	802	20	401	(401)	1,418	12
13	Allocated from 8131 N. Monticello	2013	1,394	12	20	70	58	70	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	Related Party Information Continued		$	$		$	$	$	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
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 28,790	$ 1,473		$ 1,057	$ (416)	$ 3,414	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 495,729	$ 270	$ 49,599	$ 49,329	10	$ 575,589	71
72	Current Year Purchases	21,283	60	1,772	1,712	10	1,772	72
73	Fully Depreciated Assets	545,180				10	545,180	73
74								74
75	TOTALS	$ 1,062,192	$ 330	$ 51,371	$ 51,041		$ 1,122,541	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		1999 Ford Super Duty F-250	2013	$ 10,000	$	$ 2,000	$ 2,000	5	$ 2,000	76
77		2013 GMC Savana Van	2013	54,662		10,932	10,932	5	10,932	77
78		Ford Club Wagon	2008	6,356				5	6,356	78
79		See Supplemental Schedule		7,657	188	188		5	7,219	79
80	TOTALS			$ 78,675	$ 188	$ 13,120	$ 12,932		$ 26,507	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)	$ 4,490,732	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 5,507	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 170,817	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 165,310	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,177,361	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [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:				$			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: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 1,325 Description: See Attached Schedule
    (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	Allocated from YAM Consulting		$	$ 957	17
18	Allocated from YAM Management			693	18
19					19
20					20
21	TOTAL		$	$ 1,650	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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?
   - [ ] YES
   - [X] 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)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	39 - 03	hrs	$		$ 67,819	$ 1,911		$ 69,730	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	20,610		41,030			61,640	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	320,719		57,822			378,541	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				183,781		183,781	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						23,741		23,741	13
14	TOTAL			$ 341,329		$ 166,671	$ 209,433		$ 717,433	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (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	$ 270,455	$	1
2	Cash-Patient Deposits	1,821		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,735,297		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	136,362		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	5,800		8
9	Other(specify): See Attached Schedule	51,980		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,201,715	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	31,559		15
16	Equipment, at Historical Cost	82,012		16
17	Accumulated Depreciation (book methods)	(3,516)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	2,393,500		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,503,555	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,705,270	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 450,866	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,639		28
29	Short-Term Notes Payable	931,384		29
30	Accrued Salaries Payable	238,710		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,855		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,204		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	2,898,296		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,556,954	$	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				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,556,954	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 148,316	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,705,270	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,615,135)	1
2	Restatements (describe):		2
3	**Prior Owner ADJ**	1,392,224	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (222,911)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	371,227	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)**	$ 371,227	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)**	$ 148,316	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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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	$ 8,124,471	1
2	Discounts and Allowances for all Levels	(798,666)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,325,805	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	579,618	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 579,618	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	53,746	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,015	19
20	Radiology and X-Ray	1,643	20
21	Other Medical Services	2,247	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 63,651	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	97	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 97	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	298,329	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 298,329	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,267,500	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,401,813	31
32	Health Care	2,717,458	32
33	General Administration	1,754,185	33
	B. Capital Expense		
34	Ownership	619,412	34
	C. Ancillary Expense		
35	Special Cost Centers	975,127	35
36	Provider Participation Fee	428,278	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,896,273	40
41	**Income before Income Taxes (line 30 minus line 40)****	371,227	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 371,227	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,717,278	44
45	Private Pay - Net Inpatient Revenue	1,366,169	45
46	Medicare - Net Inpatient Revenue	1,117,405	46
47	Other-(specify) Insurance	124,953	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,325,805	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,719	1,824	$ 69,714	$ 38.23	1
2	Assistant Director of Nursing	2,272	2,342	77,626	33.15	2
3	Registered Nurses	14,060	14,857	379,802	25.56	3
4	Licensed Practical Nurses	21,916	24,718	590,019	23.87	4
5	CNAs & Orderlies	67,667	70,618	862,949	12.22	5
6	CNA Trainees					6
7	Licensed Therapist	4,223	5,211	341,329	65.50	7
8	Rehab/Therapy Aides	6,359	6,679	94,170	14.10	8
9	Activity Director	2,875	3,004	55,992	18.64	9
10	Activity Assistants	15,585	16,112	173,207	10.75	10
11	Social Service Workers	9,534	10,082	202,236	20.06	11
12	Dietician					12
13	Food Service Supervisor	649	669	17,469	26.13	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,820	6,505	76,861	11.82	15
16	Dishwashers					16
17	Maintenance Workers	4,078	4,346	62,630	14.41	17
18	Housekeepers	20,702	21,592	219,593	10.17	18
19	Laundry	5,264	5,429	60,856	11.21	19
20	Administrator	1,555	1,674	79,705	47.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	398	450	10,400	23.12	23
24	Clerical	22,078	22,636	275,253	12.16	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	624	644	7,822	12.14	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,149	1,166	13,728	11.77	33
34	TOTAL (lines 1 - 33)	208,527	220,558	$ 3,671,361 *	$ 16.65	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	241	$ 11,525	01-03	35
36	Medical Director	Monthly	21,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	104	7,800	10-03	38
39	Pharmacist Consultant	Monthly	8,208	10-03	39
40	Physical Therapy Consultant	39/Monthly	13,589	10a-03	40
41	Occupational Therapy Consultant	Monthly	23,843	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	25	1,657	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	370	$ 87,622		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jodi Jude	Administrator	0.00%	$ 79,705
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 79,705

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
ProPay HR	Payroll Services	$ 9,601
E-Health Data	Data Processing	55
Sorin Rand	Legal	109
Yam Management	Accounting	6,000
Yam Management	Data Processing	5,352
Yam Management	Bookeeping	33,307
Lifecare Software Solutions	Data Processing	9,848
Galaxy Hosted Software	Data Processing	7,350
Ability Network	Data Processing	2,790
Tik Tak IT Solutions	Data Processing	384
American Data	Data Processing	7,810
See Supplemental Schedule		120,531
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 203,137

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 242,768
Unemployment Compensation Insurance	206,718
FICA Taxes	280,859
Employee Health Insurance	26,977
Employee Meals	140
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	2,843
Life Insurance	1,896
401K Expense	16,096
TOTAL (agree to Schedule V, line 22, col.8)	$ 778,297

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	3,832
Health Care Worker Background Check	11,306
(Indicate # of checks performed 1130)	
Patient Background Checks	
Licenses and Permits	2,765
Allocated from YAM Consulting	883
Allocated From YAM Mgmt	268
Allocated from 8131 N. Monticello	6
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,040

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,371
Allocated from YAM Consulting	231
Allocated From YAM Mgmt	111
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,713

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Island City Rehab Center # 0052506 Report Period Beginning: 01/01/13 Ending: 12/31/13

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(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. $ **N/A** 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. $ **428,278**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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. $ **140** Has any meal income been offset against related costs? **N/A** 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? **100% ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
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? **No**
Firm Name: **N/A**

(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? **Will Forward When Available**
Attach invoices and a summary of services for all architect and appraisal fees.