FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0049866

Facility Name: Rock Island Nsg & Rehab Ctr

Address: 2545 24th Street (Number) Rock Island (City) 61201 (Zip Code)

County: Rock Island

Telephone Number: (309) 788-0458 **Fax #** (309) 788-5234

HFS ID Number:

Date of Initial License for Current Owners: 3/6/1997

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 Drazner, 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 Rock Island Nsg & Rehab Ctr # 0049866 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	177	Skilled (SNF)	177	64,605	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	177	TOTALS	177	64,605	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	1,239		4,349	5,588	8
9	SNF/PED					9
10	ICF	37,519	1,346		38,865	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,758	1,346	4,349	44,453	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.81%

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 3/6/1997

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/6/1997 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 177 and days of care provided 2,448

Medicare Intermediary CGS Administrators

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 Rock Island Nsg & Rehab Ctr # 0049866 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	204,576	33,613	38,136	276,325		276,325	(16,297)	260,028			1
2	Food Purchase		256,621		256,621	(18,192)	238,429	(78)	238,352			2
3	Housekeeping	173,909	36,372		210,281		210,281		210,281			3
4	Laundry	80,358	27,320	10,740	118,418		118,418		118,418			4
5	Heat and Other Utilities			188,294	188,294		188,294	(23,054)	165,240			5
6	Maintenance	52,793	42,602	159,968	255,363		255,363	3,248	258,611			6
7	Other (specify):*							2,534	2,534			7
8	TOTAL General Services	511,636	396,528	397,138	1,305,302	(18,192)	1,287,110	(33,647)	1,253,464			8
	B. Health Care and Programs											
9	Medical Director			47,400	47,400		47,400		47,400			9
10	Nursing and Medical Records	1,976,472	335,371	61,486	2,373,329		2,373,329	(44,694)	2,328,635			10
10a	Therapy	99,709		29,076	128,785		128,785	(7,405)	121,380			10a
11	Activities	106,081	10,913		116,994		116,994		116,994			11
12	Social Services	164,133		5,312	169,445		169,445		169,445			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							2,813	2,813			15
16	TOTAL Health Care and Programs	2,346,395	346,284	143,274	2,835,953		2,835,953	(49,286)	2,786,667			16
	C. General Administration											
17	Administrative	80,691		305,214	385,905		385,905	(229,055)	156,850			17
18	Directors Fees											18
19	Professional Services			200,931	200,931	(83)	200,848	(134,370)	66,478			19
20	Dues, Fees, Subscriptions & Promotions			54,792	54,792		54,792	(15,432)	39,360			20
21	Clerical & General Office Expenses	101,514	22,442	308,732	432,688		432,688	(168,702)	263,986			21
22	Employee Benefits & Payroll Taxes			413,881	413,881	18,192	432,073		432,073			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,773	6,773		6,773	637	7,410			24
25	Other Admin. Staff Transportation							6,466	6,466			25
26	Insurance-Prop.Liab.Malpractice			102,457	102,457		102,457	8,127	110,584			26
27	Other (specify):*							27,247	27,247			27
28	TOTAL General Administration	182,205	22,442	1,392,780	1,597,427	18,109	1,615,536	(505,082)	1,110,454			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,040,236	765,254	1,933,192	5,738,682	(83)	5,738,599	(588,015)	5,150,584			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 Rock Island Nsg & Rehab Ctr #0049866 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			105,943	105,943		105,943	198,556	304,499			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,221	23,221		23,221	169,108	192,329			32
33	Real Estate Taxes					83	83	108,532	108,615			33
34	Rent-Facility & Grounds			468,000	468,000		468,000	(468,000)				34
35	Rent-Equipment & Vehicles			4,800	4,800		4,800	4,067	8,867			35
36	Other (specify):*							24,952	24,952			36
37	**TOTAL Ownership**			601,964	601,964	83	602,047	37,215	639,262			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	233,230	166,675	450,145	850,050		850,050		850,050			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			349,371	349,371		349,371		349,371			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	233,230	166,675	799,516	1,199,421		1,199,421		1,199,421			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,273,466	931,929	3,334,672	7,540,067		7,540,067	(550,799)	6,989,268			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 Rock Island Nsg & Rehab Ctr # 0049866 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	(24,477)	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	24,659	30		9
10	Interest and Other Investment Income	(2,931)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(78)	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				18
19	Entertainment				19
20	Contributions	(1,700)	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	(208,729)	21		24
25	Fund Raising, Advertising and Promotional	(7,021)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(39,960)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (262,236)		$	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)	(288,563)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (288,563)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (550,799)		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

STATE OF ILLINOIS **Page 5A**

Rock Island Nsg & Rehab Ctr

ID# **0049866**

Report Period Beginning: **01/01/13**

Ending: **12/31/13**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc. Income	$ (11)	21	1
2	Legal Collections	(7,664)	21	2
3	Bank Fees	(6,322)	21	3
4	Theft and Damage	(355)	21	4
5	COPE Dues	(7,017)	20	5
6	Additional R&M	4,226	06	6
7	Non-Allowable Legal	(9,418)	19	7
8	PP Oxygen	(1,287)	10	8
9	PP Dialysis	(2,348)	10	9
10	Capitalized R&M	(7,455)	06	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18	Building Co			18
19	Amortization	(2,582)	36	19
20	Fees	(250)	21	20
21	Office Expense	(2)	21	21
22	Professional Fees	(7,900)	19	22
23	Additional R&M	8,425	06	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**	(39,960)		49

Rock Island Nsg & Rehab Ctr

ID# 0049866

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 Rock Island Nsg & Rehab Ctr # 0049866 **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				(16,297)								(16,297)	1
2	Food Purchase	(78)											(78)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(24,477)			1,423								(23,054)	5
6	Maintenance	5,196	10,679	(14,644)	2,017								3,248	6
7	Other (specify):*			409	2,125								2,534	7
8	**TOTAL General Services**	(19,359)	10,679	(14,235)	(10,732)								(33,647)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(3,635)		(44,609)	5,405	(1,855)							(44,694)	10
10a	Therapy				(7,405)								(7,405)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			833	1,980								2,813	15
16	**TOTAL Health Care and Programs**	(3,635)		(43,776)	(20)	(1,855)							(49,286)	16
	C. General Administration													
17	Administrative			(286,912)	57,857								(229,055)	17
18	Directors Fees													18
19	Professional Services	(17,318)	7,900	(135,419)	10,467								(134,370)	19
20	Fees, Subscriptions & Promotions	(15,738)		306									(15,432)	20
21	Clerical & General Office Expenses	(225,333)	252	56,331	48								(168,702)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			637									637	24
25	Other Admin. Staff Transportation			6,466									6,466	25
26	Insurance-Prop.Liab.Malpractice		6,819	1,207	101								8,127	26
27	Other (specify):*			15,749	11,498								27,247	27
28	**TOTAL General Administration**	(258,389)	14,971	(341,635)	79,971								(505,082)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(281,383)	25,650	(399,646)	69,219	(1,855)							(588,015)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rock Island Nsg & Rehab Ctr # 0049866 **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	24,659	169,605		4,292								198,556	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,931)	178,610	(11,039)	4,468								169,108	32
33	Real Estate Taxes		104,414		4,118								108,532	33
34	Rent-Facility & Grounds		(468,000)										(468,000)	34
35	Rent-Equipment & Vehicles			4,067									4,067	35
36	Other (specify):*	(2,582)	27,534										24,952	36
37	**TOTAL Ownership**	19,146	12,163	(6,972)	12,878								37,215	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(262,236)	37,813	(406,618)	82,097	(1,855)							(550,799)	45

Facility Name & ID Number Rock Island Nsg & Rehab Ctr # 0049866 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 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

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)	
1	V	34	Rental Income	$ 468,000	Rock Island Real Estate, LLC	100.00%	$	$ (468,000)	1
2	V	36	Amortization		Rock Island Real Estate, LLC	100.00%	2,582	2,582	2
3	V	30	Depreciation		Rock Island Real Estate, LLC	100.00%	169,605	169,605	3
4	V	21	Fees		Rock Island Real Estate, LLC	100.00%	250	250	4
5	V	26	Insurance		Rock Island Real Estate, LLC	100.00%	6,819	6,819	5
6	V	32	Interest Expense		Rock Island Real Estate, LLC	100.00%	179,158	179,158	6
7	V	36	Mortgage insurance		Rock Island Real Estate, LLC	100.00%	24,952	24,952	7
8	V	21	Office		Rock Island Real Estate, LLC	100.00%	2	2	8
9	V	19	Audit Expense		Rock Island Real Estate, LLC	100.00%	7,900	7,900	9
10	V	33	Real Estate	5,586	Rock Island Real Estate, LLC	100.00%	110,000	104,414	10
11	V	06	Repairs		Rock Island Real Estate, LLC	100.00%	10,679	10,679	11
12	V	32	Interest Income	548	Rock Island Real Estate, LLC	100.00%		(548)	12
13	V								13
14	Total			$ 474,134			$ 511,947	$ * 37,813	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nsg & Rehab Ctr # 0049866 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	6	REPAIRS AND MAINT.	$ 21,240	S.I.R. MANAGEMENT, INC.	100.00%	$ 6,596	$ (14,644)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	409	409	16
17	V	10	NURSING	50,976	S.I.R. MANAGEMENT, INC.	100.00%	6,367	(44,609)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	833	833	18
19	V	19	PROFESSIONAL FEES	148,572	S.I.R. MANAGEMENT, INC.	100.00%	10,400	(138,172)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	306	306	20
21	V	21	CLERICAL & GENERAL	50,976	S.I.R. MANAGEMENT, INC.	100.00%	36,394	(14,582)	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	637	637	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	6,466	6,466	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,207	1,207	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	5,116	5,116	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(11,039)	(11,039)	26
27	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	4,067	4,067	27
28	V								28
29	V	17	ADMINISTRATIVE	305,214	S.I.R. MANAGEMENT, INC.	100.00%	18,302	(286,912)	29
30	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	2,753	2,753	30
31	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	70,913	70,913	31
32	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	10,633	10,633	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 576,978			$ 170,360	$ * (406,618)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nsg & Rehab Ctr # 0049866 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 SALARIES	$ 21,240	S.I.R. MANAGEMENT, INC.	100.00%	$ 4,943	$ (16,297)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	650	650	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	5,405	5,405	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	704	704	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	57,857	57,857	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	10,426	10,426	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	11,498	11,498	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	16,992	S.I.R. MANAGEMENT, INC.	100.00%	9,587	(7,405)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,276	1,276	25
26	V								26
27	V	6	MAINTENANCE SALARIES	8,418	S.I.R. MANAGEMENT, INC.	100.00%	9,904	1,486	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,475	1,475	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	1,423	1,423	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	531	531	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	41	41	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	48	48	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	101	101	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	4,292	4,292	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	4,468	4,468	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	4,118	4,118	37
38	V								38
39	Total			$ 46,650			$ 128,747	$ * 82,097	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nsg & Rehab Ctr # 0049866 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	10	RESPITORY CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	(1,855)	$ (1,855)	15
16	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%			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			$			$ (1,855)	$ * (1,855)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nsg & Rehab Ctr # 0049866 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 Rock Island Nsg & Rehab Ctr # 0049866 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 Rock Island Nsg & Rehab Ctr # 0049866 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 Rock Island Nsg & Rehab Ctr # 0049866 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 Rock Island Nsg & Rehab Ctr # 0049866 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 Rock Island Nsg & Rehab Ctr # 0049866 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 Rock Island Nsg & Rehab Ctr # 0049866 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	ATTIED ASSOCIATES	28.4369%	ALBANY CARE INC	EVANSTON	ROCK ISLAND REAL ESTATE	LINCOLNWOOD	BUILDING CO.	1
2	BRYAN BARRISH TRUST DTD 09/01/2004	9.4790%	APPLEWOOD REHABILITATION CENTER,LLC	MATTESON	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	BARRISH GROUP LIMTED PARTNERSHIP	9.4789%	BRYN MAWR CARE INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	UNITED TRUST #1	4.7395%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	LONGTERM CARE LAB	ELK GROVE VILLAGE	LABORATORY	4
5	UNITED TRUST #2	4.7395%	DECATUR MANOR HEALTHCARE,LLC	DECATUR				5
6	RALPH GESUALDO	9.4790%	ELMWOOD CARE, INC.	ELMWOOD PARK				6
7	RALPH GESUALDO CHILDRENS TRUST	9.4790%	FAIRVIEW NURSING PLAZA, INC.	ROCKFORD				7
8	LOUISE BERGTHOLD	1.1299%	GREENWOOD CARE, INC.	EVANSTON				8
9	FAY CHIN	1.1299%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				9
10	LYNN ETHELL	1.1299%	REGENCY REHABILITATION CENTER,LLC	NILES				10
11	NENITA GUZMAN	1.1299%	ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				11
12	PATRICIA MCDIARMID	1.1299%	WILSON CARE, INC.	CHICAGO				12
13	RONALD NUNZIATO JR	1.1299%	WESLEY REHABILITATION CENTER	AUBURN, IN				13
14	JEFF ORAVEC	1.1299%	MAPPLEWOOD CARE	ELGIN				14
15	KIM SHELTON	1.1299%						15
16	THOMAS WINTER	5.6497%						16
17	B.G TRUST	4.7395%						17
18	L.G TRUST	4.7395%						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 Rock Island Nsg & Rehab Ctr # 0049866 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 Rock Island Nsg & Rehab Ctr # 0049866 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	Bryan Barrish	Relative	Administrative	N/A	See Attached	2.16	4.80%	Alloc. Salary	$ 10,792	17-7	1
2	Kirsten Barrish	Relative	Clerical	N/A	See Attached	2.7	5.4%	Alloc. Salary	2,719	21-7	2
3	Sarah Barrish	Relative	Administrative	N/A	See Attached	2.43	5.4%	Alloc. Salary	5,136	17-7	3
4	Louise Bergthold	Shareholder	Administrative	1.13%	See Attached	3.24	5.4%	Alloc. Salary	10,792	17-7	4
5	Andrew Chin	Relative	Clerical	N/A	See Attached	2.16	5.4%	Alloc. Salary	3,939	21-7	5
6	Fay Chin	Shareholder	Nursing	1.13%	See Attached	2.16	5.4%	Alloc. Salary	5,405	10-7	6
7	Michael Giannini	Relative	Administrative	N/A	See Attached	1.89	4.73%	Alloc. Salary	9,030	17-7	7
8	Nenita Guzman	Shareholder	Dietary	1.13%	See Attached	2.7	5.4%	Alloc. Salary	4,943	1-7	8
9	Patricia McDiarmid	Shareholder	Administrative	1.13%	See Attached	2.7	5.4%	Alloc. Salary	7,405	17-7	9
10	See Supplemental Schedule								33,147		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	$ 93,308		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 Rock Island Nsg & Rehab Ctr # 0049866 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 Rock Island Nsg & Rehab Ctr # 0049866 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: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	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	6	REPAIRS AND MAINT.	PATIENT DAYS	823,778	14	$ 122,226	$ 54,106	44,453	$ 6,596	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	823,778	14	7,581		44,453	409	2
3	10	NURSING	PATIENT DAYS	823,778	14	117,990	117,990	44,453	6,367	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	823,778	14	15,435		44,453	833	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	823,778	14	192,718	109,921	44,453	10,400	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	823,778	14	5,665		44,453	306	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	823,778	14	674,435	608,408	44,453	36,394	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	823,778	14	11,805		44,453	637	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	823,778	14	119,815		44,453	6,466	9
10	26	INSURANCE	PATIENT DAYS	823,778	14	22,368		44,453	1,207	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	823,778	14	94,799		44,453	5,116	11
12	32	INTEREST	PATIENT DAYS	823,778	14	(204,568)		44,453	(11,039)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	823,778	14	75,364		44,453	4,067	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	823,778	14	339,156	339,156	44,453	18,302	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	823,778	14	51,011		44,453	2,753	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	823,778	14	1,314,118	1,179,981	44,453	70,913	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	823,778	14	197,046		44,453	10,633	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,156,964	$ 2,409,562		$ 170,360	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nsg & Rehab Ctr # 0049866 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: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	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 SALARIES	PATIENT DAYS	823,778	14	$ 91,605	$ 91,605	44,453	$ 4,943	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	823,778	14	12,049		44,453	650	2
3	10	NURSING SALARIES	PATIENT DAYS	823,778	14	100,168	100,168	44,453	5,405	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	823,778	14	13,047		44,453	704	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	823,778	14	1,072,182	1,072,182	44,453	57,857	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	823,778	14	193,200		44,453	10,426	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	823,778	14	213,069		44,453	11,498	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	293,544	14	165,622	165,622	16,992	9,587	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	293,544	14	22,047		16,992	1,276	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	378,109	14	444,871	444,871	8,418	9,904	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	378,109	14	66,242		8,418	1,475	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	14	26,365		695	1,423	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	14	9,845		695	531	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	14	768		695	41	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	14	896		695	48	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	14	1,870		695	101	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	14	79,536		695	4,292	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	14	82,793		695	4,468	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	14	76,319		695	4,118	23
24										24
25	TOTALS					$ 2,672,494	$ 1,874,448		$ 128,747	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nsg & Rehab Ctr # 0049866 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: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	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	10	RESPITORY CONSULTANT	LEASING INCOME	100	2	(18,548)		90	(1,855)	1
2	30	DEPRECIATION	LEASING INCOME	100	2	-		90		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					$	$		$ (1,855)	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nsg & Rehab Ctr # 0049866 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 Rock Island Nsg & Rehab Ctr # 0049866 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 Rock Island Nsg & Rehab Ctr # 0049866 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 Rock Island Nsg & Rehab Ctr # 0049866 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 Rock Island Nsg & Rehab Ctr # 0049866 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 Rock Island Nsg & Rehab Ctr # 0049866 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 Rock Island Nsg & Rehab Ctr # 0049866 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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Centrue Bank		X	Mortgage Payable			$	$ 4,944,000			$ 179,158	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Allocated from SIR Mgmt		X								4,468	6
7	Lake Forest Bank & Trust		X	Line of Credit				980,000			23,221	7
8												8
9	TOTAL Facility Related						$	$ 5,924,000			$ 206,847	9
	B. Non-Facility Related*											
10	Allocated from SIR Mgmt		X								(11,039)	10
11	Interest Income		X								(2,931)	11
12	Interest Income - Bldg. Co.		X								(548)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (14,518)	14
15	TOTALS (line 9+line14)						$	$ 5,924,000			$ 192,329	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 24,952 Line # 36

* 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 Rock Island Nsg & Rehab Ctr # 0049866 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							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											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 Rock Island Nsg & Rehab Ctr # 0049866 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.**	$ 110,000	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.)		$ 108,532	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,468)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 110,000	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.)		$ 83	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.		$ 108,615	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	124,475	8
	2009	103,404	9
	2010	104,880	10
	2011	105,189	11
	2012	104,414	12

2013 Accrual = $104,414 x 1.05 = $110,000 (Rounded)

Allocation from SIR Management = $4,118

	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 Rock Island Nsg & Rehab Ctr COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0049866

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.	10-341-78-00	Long Term Care Property	$ 102,947.68	$ 102,947.68
2.	10-341-79-00	Long Term Care Property	$ 1,466.28	$ 1,466.28
3.	See Attached	See Attached	$ 106,516.99	$ 4,501.63
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 210,930.95	$ 108,915.59

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 Rock Island Nsg & Rehab Ctr COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0049866

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 Rock Island Nsg & Rehab Ctr # 0049866 Report Period Beginning: 01/01/13 Ending: 12/31/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 54,494 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 4+ Basement

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).

N/A

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	Facility	224,770	1997	$ 420,000	1
2					2
3	TOTALS	224,770		$ 420,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nsg & Rehab Ctr # 0049866 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	177			1975	$ 3,579,244	$ 89,323	39	$ 92,208	$ 2,885	$ 1,502,265	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2002	10,887		20	396	396	4,383	9
10	Various			2003	5,954		20	216	216	2,181	10
11	Various			2004	9,240		20	336	336	3,206	11
12	Various			2005	48,760		20	2,139	2,139	18,094	12
13	Various			2006	39,068		20	1,421	1,421	11,043	13
14	Various			2008	539,334		20	52,208	52,208	293,193	14
15	Various			2009	265,059		20	15,135	15,135	69,192	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nsg & Rehab Ctr # 0049866 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)		340,690	18,024		19,245	1,221	122,519	67
68	Related Party Allocations (Pages 12H & 12I)		97,795	2,717		3,820	1,103	44,164	68
69	Financial Statement Depreciation			105,943			(105,943)		69
70	TOTAL (lines 4 thru 69)		$ 4,936,031	$ 216,007		$ 187,123	$ (28,884)	$ 2,070,240	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rock Island Nsg & Rehab Ctr # 0049866 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		$ 4,936,031	$ 216,007		$ 187,123	$ (28,884)	$ 2,070,240	1
2	Receptacles	2010	8,185		20	1,637	1,637	5,047	2
3	Chiller Conduit	2010	5,557		20	278	278	1,065	3
4	12 Volt Circuit	2010	3,738		20	187	187	716	4
5	Door Alarm Repair	2010	4,190		20	210	210	786	5
6	Compressor	2011	5,038		20	252	252	651	6
7	Security Camera System	2011	8,917		20	446	446	1,115	7
8	Hair Salon Door	2011	3,120		20	312	312	676	8
9	Door Locks & Alarm Repairs	2011	2,669		20	133	133	345	9
10	Compressor Repair	2011	2,666		20	133	133	333	10
11	Hand Rail Bars	2012	2,524		20	126	126	179	11
12	Installed 8'X12' Greenhouse	2013	3,550		20	133	133	133	12
13	Dialysis Room Architect Work	2013	4,870		20	142	142	142	13
14	Therapy Room Window Treatments	2013	6,901		20	115	115	115	14
15	Lobby Window Treatments	2013	6,602		20	83	83	83	15
16	Handrails	2013	2,923		20	146	146	146	16
17	Installed Flooring & Wall Base On 4Th Floor Alsheimer Activity R	2013	26,569		20	1,328	1,328	1,328	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)		$ 5,034,051	$ 216,007		$ 192,784	$ (23,223)	$ 2,083,099	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rock Island Nsg & Rehab Ctr # 0049866 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		$ 5,034,051	$ 216,007		$ 192,784	$ (23,223)	$ 2,083,099	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)		$ 5,034,051	$ 216,007		$ 192,784	$ (23,223)	$ 2,083,099	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rock Island Nsg & Rehab Ctr # 0049866 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		$ 5,034,051	$ 216,007		$ 192,784	$ (23,223)	$ 2,083,099	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)		$ 5,034,051	$ 216,007		$ 192,784	$ (23,223)	$ 2,083,099	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rock Island Nsg & Rehab Ctr # 0049866 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		$ 5,034,051	$ 216,007		$ 192,784	$ (23,223)	$ 2,083,099	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)		$ 5,034,051	$ 216,007		$ 192,784	$ (23,223)	$ 2,083,099	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rock Island Nsg & Rehab Ctr # 0049866 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	Flooring, Wallcovering, Window Treatment, Doors	1997	50,964		20	3,310	3,310	39,537	9
10	Windows	1998	2,278		20	114	114	1,291	10
11	Walk-In Freezer Compressor	2000	2,097		20	1,095	1,095	2,097	11
12	Electrical Work	2001	1,854		20	93	93	1,034	12
13	Water Heater	2008	6,570		20	329	329	3,619	13
14	Handrails	2008	100,904		20	5,045	5,045	55,495	14
15	Electrical Work - Resident Rooms	2010	7,985		20	399	399	1,596	15
16	Wall Removal - 4th Floor Dining	2010	7,000		20	405	405	1,620	16
17	Outdoor Fence	2010	6,570		20	329	329	1,316	17
18	Kitchen Lighting	2010	8,026		20	803	803	3,212	18
19	Flooring - Carpet and Tile	2011	7,869		20	393	393	1,179	19
20	Fire-Sprinkler Heads	2011	2,790		20	140	140	420	20
21	Outdoor Facility Sign	2012	10,113		20	506	506	1,012	21
22	Compressor for Walk-in Freezer	2012	5,820		20	291	291	582	22
23	Dialysis Room-New: Construction, plumbing, HVAC & Electrical	2012	42,518		20	2,126	2,126	4,252	23
24	Nurse Call System	2012	7,800		20	390	390	780	24
25	Installed Amtico Flooring On 1st Floor Therapy Room	2013	9,999		20	500	500	500	25
26	Installed Cabintery, Countertop Finish & Molding in Physcial	2013	12,400		20	620	620	620	26
27	Installed Nurse Station	2013	25,000		20	1,250	1,250	1,250	27
28	Installed Elevator Panel	2013	8,000		20	400	400	400	28
29	Installed Cabintery	2013	5,000		20	250	250	250	29
30	Replacement Windows	2013	9,133		20	457	457	457	30
31									31
32	Depreciation			18,024			(18,024)		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 Rock Island Nsg & Rehab Ctr # 0049866 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
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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)		$ 340,690	$ 18,024		$ 19,245	$ 1,221	$ 122,519	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rock Island Nsg & Rehab Ctr # 0049866 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	Alloc. - S.I.R. Management	2009	13,491		39	346	346	1,398	3
4	Alloc. - S.I.R. Properties - S.I.R. Management	1993	24,427	775	35	698	(77)	14,307	4
5									5
6									6
7									7
8	Leasehold Information								8
9	Alloc. - S.I.R. Management	1993	6,193	172	20	53	(119)	6,193	9
10	Alloc. - S.I.R. Management	1994	19		20			19	10
11	Alloc. - S.I.R. Management	1995	142		20	7	7	130	11
12	Alloc. - S.I.R. Management	1997	9,516	213	20	464	251	7,965	12
13	Alloc. - S.I.R. Management	1999	748		20	37	37	533	13
14	Alloc. - S.I.R. Management	1999							14
15	Alloc. - S.I.R. Management	2000	883		20	44	44	598	15
16	Alloc. - S.I.R. Management	2007	2,838	194	20	142	(52)	879	16
17	Alloc. - S.I.R. Management	2008	7,823	747	20	493	(254)	2,882	17
18	Alloc. - S.I.R. Management	2009	19,438	178	20	972	794	4,125	18
19	Alloc. - S.I.R. Management	2011	481	48	20	48		116	19
20	Alloc. - S.I.R. Management	2012	1,539	77	20	77		109	20
21									21
22	Alloc. - S.I.R. Properties - S.I.R. Management	2012	1,496	206	20	10	(196)	12	22
23	Alloc. - S.I.R. Properties - S.I.R. Management	2010	1,474		20	74	74	246	23
24	Alloc. - S.I.R. Properties - S.I.R. Management	2009	1,467	65	20	73	8	352	24
25	Alloc. - S.I.R. Properties - S.I.R. Management	2007	428	34	20	21	(13)	150	25
26	Alloc. - S.I.R. Properties - S.I.R. Management	2002	97		20	5	5	56	26
27	Alloc. - S.I.R. Properties - S.I.R. Management	1999	3,095		20	155	155	2,244	27
28	Alloc. - S.I.R. Properties - S.I.R. Management	1998	1,479		20	74	74	1,146	28
29	Alloc. - S.I.R. Properties - S.I.R. Management	1997	92		20	5	5	81	29
30	Alloc. - S.I.R. Properties - S.I.R. Management	1994	233	6	20	12	6	227	30
31	Alloc. - S.I.R. Properties - S.I.R. Management	1993	396	2	20	10	8	396	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 Rock Island Nsg & Rehab Ctr # 0049866 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
15									15
16									16
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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)		$ 97,795	$ 2,717		$ 3,820	$ 1,103	$ 44,164	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rock Island Nsg & Rehab Ctr # 0049866 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	$ 1,028,379	$ 57,991	$ 107,847	$ 49,856	10	$ 493,189	71
72	Current Year Purchases	44,166	5,641	3,620	(2,021)	10	4,462	72
73	Fully Depreciated Assets	292,529		17	17	10	292,529	73
74								74
75	TOTALS	$ 1,365,074	$ 63,632	$ 111,485	$ 47,853		$ 790,180	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		Allocated S.I.R. Management	2013	$ 1,897	$ 198	$ 227	$ 29	5	$ 890	76
77										77
78										78
79										79
80	TOTALS			$ 1,897	$ 198	$ 227	$ 29		$ 890	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,821,022	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 279,837	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 304,496	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 24,659	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,874,169	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rock Island Nsg & Rehab Ctr # 0049866 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. ☐ 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: $ 8,867 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			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nsg & Rehab Ctr # 0049866 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 Rock Island Nsg & Rehab Ctr # 0049866 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	$		$ 129,037	$		$ 129,037	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			84,204			84,204	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			166,967			166,967	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				122,035		122,035	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			233,230		69,937	44,640		347,807	13
14	TOTAL			$ 233,230		$ 450,145	$ 166,675		$ 850,050	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

Facility Name & ID Number Rock Island Nsg & Rehab Ctr # 0049866 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	$ 123,777	$ 137,367	1
2	Cash-Patient Deposits	59,337	59,337	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,768,146	1,768,146	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,170	26,740	6
7	Other Prepaid Expenses	1,494	1,494	7
8	Accounts Receivable (owners or related parties)	130,000	130,000	8
9	Other(specify):		647,063	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,108,924	$ 2,770,147	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		420,000	13
14	Buildings, at Historical Cost		3,483,607	14
15	Leasehold Improvements, at Historical Cost	762,432	1,027,238	15
16	Equipment, at Historical Cost	547,613	1,185,247	16
17	Accumulated Depreciation (book methods)	(543,053)	(1,128,143)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		25,719	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(25,719)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	1,000	1,078,473	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 767,992	$ 6,066,422	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,876,916	$ 8,836,569	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 285,756	$ 285,756	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	59,446	59,446	28
29	Short-Term Notes Payable	980,000	980,000	29
30	Accrued Salaries Payable	211,001	211,001	30
31	Accrued Taxes Payable (excluding real estate taxes)	25,136	25,136	31
32	Accrued Real Estate Taxes(Sch.IX-B)		110,000	32
33	Accrued Interest Payable		14,791	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	10,000	10,000	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	178,876	178,876	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,750,215	$ 1,875,006	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,944,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43			5,379	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,949,379	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,750,215	$ 6,824,385	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,126,701	$ 2,012,184	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,876,916	$ 8,836,569	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Rock Island Nsg & Rehab Ctr # 0049866 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**	$ 876,446	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 876,446	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	250,255	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)**	$ 250,255	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)**	$ 1,126,701	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nsg & Rehab Ctr # 0049866 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 7,291,995	1
2	Discounts and Allowances for all Levels	(1,257,016)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,034,979	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,404,658	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,404,658	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	118,113	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,814	19
20	Radiology and X-Ray	363	20
21	Other Medical Services	94,976	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 224,266	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,931	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,931	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	123,488	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 123,488	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,790,322	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,305,302	31
32	Health Care	2,835,953	32
33	General Administration	1,597,427	33
	B. Capital Expense		
34	Ownership	601,964	34
	C. Ancillary Expense		
35	Special Cost Centers	850,050	35
36	Provider Participation Fee	349,371	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,540,067	40
41	**Income before Income Taxes (line 30 minus line 40)****	250,255	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 250,255	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,360,800	44
45	Private Pay - Net Inpatient Revenue	238,613	45
46	Medicare - Net Inpatient Revenue	179,528	46
47	Other-(specify) Hospice	171,987	47
48	Other-(specify) HMO/Insurance	84,051	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,034,979	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 Rock Island Nsg & Rehab Ctr # 0049866 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	1,949	2,086	$ 66,905	$ 32.07	1
2	Assistant Director of Nursing	1,973	2,086	53,019	25.42	2
3	Registered Nurses	10,095	10,419	251,354	24.12	3
4	Licensed Practical Nurses	30,745	33,101	635,683	19.20	4
5	CNAs & Orderlies	78,436	78,559	861,241	10.96	5
6	CNA Trainees					6
7	Licensed Therapist	8,903	9,334	233,230	24.99	7
8	Rehab/Therapy Aides	7,348	7,656	99,709	13.02	8
9	Activity Director	2,045	2,230	32,626	14.63	9
10	Activity Assistants	6,540	6,894	73,455	10.65	10
11	Social Service Workers	11,881	12,538	164,133	13.09	11
12	Dietician					12
13	Food Service Supervisor	2,538	2,626	39,460	15.03	13
14	Head Cook	10,781	11,249	102,794	9.14	14
15	Cook Helpers/Assistants	7,387	7,387	62,322	8.44	15
16	Dishwashers					16
17	Maintenance Workers	3,986	4,239	52,793	12.45	17
18	Housekeepers	16,714	17,527	173,909	9.92	18
19	Laundry	8,134	8,469	80,358	9.49	19
20	Administrator	2,024	2,587	80,691	31.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,207	7,395	101,514	13.73	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	6,375	6,676	108,270	16.22	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	225,061	233,058	$ 3,273,466 *	$ 14.05	34

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	Monthly	$ 16,896	01-03	35
36	Medical Director	Monthly	47,400	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	50,976	10-03	38
39	Pharmacist Consultant	Monthly	10,510	10-03	39
40	Physical Therapy Consultant	Monthly	3,435	10a-03	40
41	Occupational Therapy Consultant	Monthly	3,566	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	5,083	10a-03	43
44	Activity Consultant				44
45	Social Service Consultant	83	5,312	12-03	45
46	Other(specify) Director of Food Serv	Monthly	21,240	01-03	46
47	Specialized Services	Monthly	16,992	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	83	$ 181,410		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Rock Island Nsg & Rehab Ctr # 0049866 Report Period Beginning: 01/01/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dawn Vincent	Administrator	0%	$ 65,578
Shaila Hart	Administrator	0%	15,114
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 80,691

B. Administrative - Other

Description	Amount
SIR Management - Director of Administrative Services	$ 50,976
SIR Management - Ancillary Administrative Charges	42,480
SIR Management - Consulting Fee	211,758
TOTAL (agree to Schedule V, line 17, col. 3)	$ 305,214
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SIR Management	Dir of Regulatory Services	$ 25,488
SIR Management	Bookkeeping Fees	87,084
SIR Management	Accounting Fees	36,000
FR&R	Accounting Fees	14,535
Plante Moran	Medicare	4,125
H.K Payroll	Payroll	3,430
Pinnacle	Customer Satisfaction	2,731
E-Health	Data Processing	3,300
Achieve Accreditation	Acceditation Services	10,525
Dawn Vincent	Consulting Services	715
Personel Planners	Unemployment Consulting	2,296
See Supplemental Schedule		10,702
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 200,931

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,885
Unemployment Compensation Insurance	57,367
FICA Taxes	246,240
Employee Health Insurance	45,221
Employee Meals	18,192
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits-Other	9,168
TOTAL (agree to Schedule V, line 22, col.8)	$ 432,072

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	$ 1,992
Advertising: Employee Recruitment	20,257
Health Care Worker Background Check	
(Indicate # of checks performed 104)	2,263
Patient Background Checks 50	500
Dues and Subscriptions	4,985
Dues and Subscriptions- Il Council	7,108
Licsenses and Permits	1,950
Allocated from SIR Management	306
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 39,361

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,773
Allocated from SIR Management	637
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,410

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rock Island Nsg & Rehab Ctr # 0049866 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 Rock Island Nsg & Rehab Ctr # 0049866 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? **Yes**
If YES, give association name and amount. **ILCLTC $14,124.6**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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. $ **1,985** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? **X** YES ____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO ____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
River Park Healthcare Center #0042549

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **349,371**
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. $ **18,192** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.