FOR BHF USE

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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

I. IDPH License ID Number: 0049866

Facility Name: Rock Island Nursing And Rehab Center

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) 282-6300
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 01/01/15 to 12/31/15 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)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	896		6,270	7,166	8
9	SNF/PED					9
10	ICF	27,121	1,022	3,169	31,312	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,017	1,022	9,439	38,478	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.56%

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 03/06/1997

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/06/1997 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 4,067

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: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	212,634	30,394	42,495	285,523		285,523	(16,194)	269,329			1
2	Food Purchase		291,268		291,268	(23,608)	267,660	(269)	267,391			2
3	Housekeeping	142,227	44,886		187,113		187,113		187,113			3
4	Laundry	85,857	25,314	10,740	121,911		121,911		121,911			4
5	Heat and Other Utilities			194,569	194,569		194,569	(24,699)	169,870			5
6	Maintenance	67,437	33,579	138,394	239,410		239,410	(5,341)	234,069			6
7	Other (specify):*							3,144	3,144			7
8	**TOTAL General Services**	508,155	425,441	386,198	1,319,794	(23,608)	1,296,186	(43,360)	1,252,826			8
	B. Health Care and Programs											
9	Medical Director			44,825	44,825		44,825		44,825			9
10	Nursing and Medical Records	2,111,452	433,272	118,800	2,663,524		2,663,524	(18,933)	2,644,591			10
10a	Therapy	106,920		38,977	145,897		145,897	(8,105)	137,792			10a
11	Activities	103,963	9,331		113,294		113,294		113,294			11
12	Social Services	139,090		3,628	142,718		142,718		142,718			12
13	CNA Training											13
14	Program Transportation			539	539		539		539			14
15	Other (specify):*							4,435	4,435			15
16	**TOTAL Health Care and Programs**	2,461,425	442,603	206,769	3,110,797		3,110,797	(22,603)	3,088,194			16
	C. General Administration											
17	Administrative	94,288		93,456	187,744		187,744	(18,350)	169,394			17
18	Directors Fees											18
19	Professional Services			270,586	270,586		270,586	(181,467)	89,119			19
20	Dues, Fees, Subscriptions & Promotions			72,251	72,251		72,251	(22,384)	49,867			20
21	Clerical & General Office Expenses	142,253	36,240	454,660	633,153		633,153	(332,723)	300,430			21
22	Employee Benefits & Payroll Taxes			451,385	451,385	23,608	474,993		474,993			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,035	1,035		1,035	813	1,848			24
25	Other Admin. Staff Transportation			7,723	7,723		7,723	4,810	12,533			25
26	Insurance-Prop.Liab.Malpractice			144,052	144,052		144,052	8,956	153,008			26
27	Other (specify):*							27,173	27,173			27
28	**TOTAL General Administration**	236,541	36,240	1,495,148	1,767,929	23,608	1,791,537	(513,172)	1,278,365			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,206,121	904,284	2,088,115	6,198,520		6,198,520	(579,135)	5,619,385			29

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

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

Facility Name & ID Number Rock Island Nursing And Rehab Center #0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			109,005	109,005		109,005	185,824	294,829			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			77,985	77,985		77,985	163,488	241,473			32
33	Real Estate Taxes							109,801	109,801			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(480,000)				34
35	Rent-Equipment & Vehicles			1,827	1,827		1,827	4,573	6,400			35
36	Other (specify):*							23,907	23,907			36
37	TOTAL Ownership			668,817	668,817		668,817	7,593	676,410			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	256,088	292,950	463,402	1,012,440		1,012,440		1,012,440			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			312,940	312,940		312,940		312,940			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	256,088	292,950	776,342	1,325,380		1,325,380		1,325,380			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,462,209	1,197,234	3,533,274	8,192,717		8,192,717	(571,543)	7,621,174			45

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	(192)	02		4
5	Telephone, TV & Radio in Resident Rooms	(26,317)	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	(1,265)	30		9
10	Interest and Other Investment Income	(2,472)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(77)	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	(3,533)	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	(392,060)	21		24
25	Fund Raising, Advertising and Promotional	(11,833)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(43,940)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (481,690)		$	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)	(89,853)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (89,853)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (571,543)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Rock Island Nursing And Rehab Center

ID# 0049866

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Legal Collections	$ (7,805)	19	1
2	Bank Fees	(7,125)	21	2
3	Theft & Damage	(3,736)	21	3
4	PAC Dues	(8,139)	20	4
5	Bldg. Co. - Professional Fees	(8,300)	19	5
6	Bldg. Co. - Fees	(250)	21	6
7	Additional R&M	3,985	06	7
8	Non Allowable Legal Fees	(9,888)	19	8
9	Bldg. Co. - Amortization	(2,582)	36	9
10	Marketing Salary	(100)	21	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(43,940)		49

Rock Island Nursing And Rehab Center

ID# 0049866

Report Period Beginning: 01/01/15

Ending: 12/31/15

	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			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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				(16,194)								(16,194)	1
2	Food Purchase	(269)											(269)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(26,317)			1,618								(24,699)	5
6	Maintenance	3,985	1,784	(17,846)	6,736								(5,341)	6
7	Other (specify):*				3,144								3,144	7
8	**TOTAL General Services**	(22,601)	1,784	(17,846)	(4,697)								(43,360)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(24,498)	5,565								(18,933)	10
10a	Therapy				(8,105)								(8,105)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			2,414	2,021								4,435	15
16	**TOTAL Health Care and Programs**			(22,084)	(519)								(22,603)	16
	C. General Administration													
17	Administrative			(75,364)	57,014								(18,350)	17
18	Directors Fees													18
19	Professional Services	(25,993)	8,300	(174,612)	10,838								(181,467)	19
20	Fees, Subscriptions & Promotions	(23,505)		1,121									(22,384)	20
21	Clerical & General Office Expenses	(403,271)	250	70,226	72								(332,723)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			813									813	24
25	Other Admin. Staff Transportation			4,810									4,810	25
26	Insurance-Prop.Liab.Malpractice		7,352	1,447	157								8,956	26
27	Other (specify):*			14,875	12,298								27,173	27
28	**TOTAL General Administration**	(452,769)	15,902	(156,684)	80,379								(513,172)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(475,371)	17,686	(196,614)	75,163								(579,135)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(1,265)	182,081		5,008								185,824	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,472)	171,197	(9,691)	4,454								163,488	32
33	Real Estate Taxes		104,020		5,781								109,801	33
34	Rent-Facility & Grounds		(480,000)										(480,000)	34
35	Rent-Equipment & Vehicles			4,573									4,573	35
36	Other (specify):*	(2,582)	26,489										23,907	36
37	**TOTAL Ownership**	(6,319)	3,787	(5,118)	15,243								7,593	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)**	(481,690)	21,473	(201,732)	90,406								(571,543)	45

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 480,000	Rock Island Real Estate, LLC	100.00%	$	$ (480,000)	1
2	V	21	Fees		Rock Island Real Estate, LLC	100.00%	250	250	2
3	V	32	Interest Expense & Income	453	Rock Island Real Estate, LLC	100.00%	171,650	171,197	3
4	V	36	Mortgage Insurance		Rock Island Real Estate, LLC	100.00%	23,907	23,907	4
5	V	19	Professional Fees		Rock Island Real Estate, LLC	100.00%	8,300	8,300	5
6	V	26	Property Insurance		Rock Island Real Estate, LLC	100.00%	7,352	7,352	6
7	V	33	Real Estate Tax	5,980	Rock Island Real Estate, LLC	100.00%	110,000	104,020	7
8	V	06	Repairs		Rock Island Real Estate, LLC	100.00%	1,784	1,784	8
9	V	36	Amort. - HUD Fees		Rock Island Real Estate, LLC	100.00%	2,582	2,582	9
10	V	30	Depreciation Expense		Rock Island Real Estate, LLC	100.00%	182,081	182,081	10
11	V								11
12	V								12
13	V								13
14	Total			$ 486,433			$ 507,906	$ * 21,473	14

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 3,394	$ (17,846)	15
16	V								16
17	V	10	NURSING	50,976	S.I.R. MANAGEMENT, INC.	100.00%	26,478	(24,498)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,414	2,414	18
19	V	19	PROFESSIONAL FEES	177,660	S.I.R. MANAGEMENT, INC.	100.00%	2,740	(174,920)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	1,121	1,121	20
21	V	21	CLERICAL & GENERAL	25,488	S.I.R. MANAGEMENT, INC.	100.00%	85,859	60,371	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	813	813	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	4,810	4,810	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,447	1,447	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,546	4,546	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(9,691)	(9,691)	26
27	V	35	AUTO RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	3,887	3,887	27
28	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	686	686	28
29	V								29
30	V	17	ADMINISTRATIVE	93,456	S.I.R. MANAGEMENT, INC.	100.00%	18,092	(75,364)	30
31	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	308	308	31
32	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	9,855	9,855	32
33	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	10,329	10,329	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 368,820			$ 167,088	$ * (201,732)	39

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 5,046	$ (16,194)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	704	704	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	5,565	5,565	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	770	770	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	57,014	57,014	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	10,785	10,785	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	12,298	12,298	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	16,992	S.I.R. MANAGEMENT, INC.	100.00%	8,887	(8,105)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,251	1,251	25
26	V								26
27	V	6	MAINTENANCE SALARIES	10,477	S.I.R. MANAGEMENT, INC.	100.00%	16,304	5,827	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	2,440	2,440	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	1,618	1,618	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	909	909	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	53	53	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	72	72	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	157	157	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	5,008	5,008	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	4,454	4,454	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	5,781	5,781	37
38	V								38
39	Total			$ 48,709			$ 139,115	$ * 90,406	39

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	5
6	RALPH GESUALDO	9.4790%	ELMWOOD CARE, INC.	ELMWOOD PARK				6
7	RALPH GESUALDO CHILDRENS TRUST	9.4790%	OAKTON PAVILION	DES PLAINES				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%						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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		See Attached	2.13	4.73%	Alloc. Salary	$ 10,670	17-7	1
2	Kirsten Schloss	Relative	Maintenance		See Attached	2.67	5.34%	Alloc. Salary	5,139	6-7	2
3	Sarah Barrish	Relative	Administrative		See Attached	2.40	5.33%	Alloc. Salary	5,621	17-7	3
4	Louise Bergthold	Shareholder	Administrative	1.13%	See Attached	3.20	5.33%	Alloc. Salary	10,670	17-7	4
5	Andrew Chin	Relative	Clerical		See Attached	2.13	5.33%	Alloc. Salary	4,117	21-7	5
6	Fay Chin	Shareholder	Nursing	1.13%	See Attached	2.13	5.33%	Alloc. Salary	5,565	10-7	6
7	Michael Giannini	Relative	Administrative		See Attached	1.87	4.68%	Alloc. Salary	9,122	17-7	7
8	Nenita Guzman	Shareholder	Dietary	1.13%	See Attached	2.67	5.34%	Alloc. Salary	5,046	1-7	8
9	Patricia McDiarmid	Shareholder	Administrative	1.13%	See Attached	2.67	5.34%	Alloc. Salary	8,805	17-7	9
10	See Supplemental Schedule				See Attached			Alloc. Salary	24,170		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	$ 88,925		13

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

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	721,222	14	$ 63,617	$	38,478	$ 3,394	1
2										2
3	10	NURSING	PATIENT DAYS	721,222	14	496,290	496,290	38,478	26,478	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	721,222	14	45,246		38,478	2,414	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	721,222	14	51,349		38,478	2,740	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	721,222	14	21,010		38,478	1,121	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	721,222	14	1,609,327	1,193,369	38,478	85,859	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	721,222	14	15,238		38,478	813	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	721,222	14	90,162		38,478	4,810	9
10	26	INSURANCE	PATIENT DAYS	721,222	14	27,120		38,478	1,447	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	721,222	14	85,206		38,478	4,546	11
12	32	INTEREST	PATIENT DAYS	721,222	14	(181,648)		38,478	(9,691)	12
13	35	AUTO RENTAL	PATIENT DAYS	721,222	14	72,863		38,478	3,887	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	721,222	14	12,850		38,478	686	14
15										15
16	17	ADMINISTRATIVE	PATIENT DAYS	721,222	14	339,119	339,119	38,478	18,092	16
17	19	PROFESSIONAL FEES	PATIENT DAYS	721,222	14	5,774		38,478	308	17
18	21	CLERICAL & GENERAL	PATIENT DAYS	721,222	14	184,716	77,164	38,478	9,855	18
19	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	721,222	14	193,599		38,478	10,329	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,131,838	$ 2,105,942		$ 167,088	25

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	721,222	14	$ 94,587	$ 94,587	38,478	$ 5,046	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	721,222	14	13,188		38,478	704	2
3	10	NURSING SALARIES	PATIENT DAYS	721,222	14	104,315	104,315	38,478	5,565	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	721,222	14	14,440		38,478	770	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	721,222	14	1,068,659	1,068,659	38,478	57,014	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	721,222	14	202,147		38,478	10,785	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	721,222	14	230,505		38,478	12,298	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	322,920	13	168,894	168,894	16,992	8,887	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	322,920	13	23,767		16,992	1,251	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	319,657	14	497,427	497,427	10,477	16,304	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	319,657	14	74,439		10,477	2,440	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,878	14	30,338		687	1,618	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,878	14	17,037		687	909	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,878	14	1,002		687	53	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,878	14	1,351		687	72	19
20	26	INSURANCE	ALLOCATED SQ FT	12,878	14	2,937		687	157	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,878	14	93,883		687	5,008	21
22	32	INTEREST	ALLOCATED SQ FT	12,878	14	83,486		687	4,454	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,878	14	108,372		687	5,781	23
24										24
25	TOTALS					$ 2,830,774	$ 1,933,882		$ 139,115	25

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			$	$ 4,731,391			$ 171,650	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Lake Forest Bank & Trust		X	Line of Credit				1,500,000			77,985	6
7	Lake Forest Bank & Trust		X	Shareholder Loan				100,000				7
8												8
9	TOTAL Facility Related						$	$ 6,331,391			$ 249,635	9
	B. Non-Facility Related*											
10	Interest Income		X								(2,472)	10
11	Interest Income - Bldg. Co.		X								(453)	11
12	Allocated from SIR Mgmt	X									(5,237)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (8,162)	14
15	TOTALS (line 9+line14)						$	$ 6,331,391			$ 241,473	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 23,907 **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.)**

**** 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 Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Nursing And Rehab Center # 0049866 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 110,608	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.)		$ 110,409	2
3. Under or (over) accrual (line 2 minus line 1).		$ (199)	3
4. Real Estate Tax accrual used for 2015 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.**		$	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.		$ 109,801	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	104,880	8
	2011	105,189	9
	2012	104,414	10
	2013	105,125	11
	2014	104,628	12

2015 Accrual = $104,628 x 1.05 = $110,000 (Rounded)

Beginning Accrual Adjusted

Allocated from SIR Management = $5,781

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rock Island Nursing And Rehab Center 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 2014 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 2014.

	(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	$ 103,158.88	$ 103,158.88
2.	10-341-79-00	Long Term Care Property	$ 1,469.24	$ 1,469.24
3.	See Attached	Allocated from SIR Management	$ 118,674.75	$ 4,958.10
4.	10-31-401-046-0000	Allocated from Regency	$ 862,948.02	$ 558.87
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,086,250.89	$ 110,145.09

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rock Island Nursing And Rehab Center 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 Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	224,770	1997	$ 420,000	1
2					2
3	TOTALS	224,770		$ 420,000	3

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 1,686,681	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2002	10,887		20	396	396	5,175	9
10	Various			2003	5,954		20	216	216	2,613	10
11	Various			2004	9,240		20	336	336	3,878	11
12	Various			2005	48,760		20	2,139	2,139	22,372	12
13	Various			2006	39,068		20	1,421	1,421	13,885	13
14	Various			2008	539,334		20	48,755	48,755	405,868	14
15	Various			2009	265,059		20	15,135	15,135	99,461	15
16	Various			2010	21,670		20	2,175	2,175	12,101	16
17	Various			2011	22,411		20	1,277	1,277	5,673	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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)		432,273	20,707		23,824	3,117	145,247	67
68	Related Party Allocations (Pages 12H & 12I)		110,226	3,109		4,048	939	53,144	68
69	Financial Statement Depreciation			109,005			(109,005)		69
70	TOTAL (lines 4 thru 69)		$ 5,084,125	$ 222,144		$ 191,929	$ (30,215)	$ 2,456,098	70

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,084,125	$ 222,144		$ 191,929	$ (30,215)	$ 2,456,098	1
2	Hand Rail Bars	2012	2,524		20	126	126	431	2
3	Installed 8' X 12' Greenhouse	2013	3,550		20	178	178	488	3
4	Dialysis Room Architect Work	2013	4,870		20	244	244	629	4
5	Therapy Room Window Treatments	2013	6,901		20	345	345	805	5
6	Lobby Window Treatments	2013	6,602		20	330	330	743	6
7	Installed Flooring & Wall Base On 4Th Floor Alzheimer Activity I	2013	26,569		20	1,328	1,328	3,985	7
8	Handrails	2013	2,923		20	146	146	304	8
9	Install New Door In Elevator #1	2014	4,538		20	227	227	435	9
10	Flooring Adm And Front Office	2014	6,766		20	338	338	423	10
11	Flooring Adm And Front Office	2014	3,369		20	168	168	211	11
12	Crashrails- 1St Floor Dining Room	2014	2,762		20	138	138	184	12
13	Crashrails- 1St Floor Dining Room	2014	2,577		20	129	129	172	13
14	Crashrails- 1St Floor Dining Room	2014	2,616		20	131	131	174	14
15	Crashrails- 1St Floor Dining Room	2014	4,934		20	247	247	329	15
16	Custom Built In - Front Reception	2014	9,000		20	450	450	638	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)		$ 5,174,626	$ 222,144		$ 196,454	$ (25,690)	$ 2,466,049	34

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 5,174,626	$ 222,144		$ 196,454	$ (25,690)	$ 2,466,049	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)		$ 5,174,626	$ 222,144		$ 196,454	$ (25,690)	$ 2,466,049	34

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 5,174,626	$ 222,144		$ 196,454	$ (25,690)	$ 2,466,049	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)		$ 5,174,626	$ 222,144		$ 196,454	$ (25,690)	$ 2,466,049	34

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 5,174,626	$ 222,144		$ 196,454	$ (25,690)	$ 2,466,049	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)		$ 5,174,626	$ 222,144		$ 196,454	$ (25,690)	$ 2,466,049	34

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$	$		$	$	$	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	42,847	9
10	Windows	1998	2,278		20	114	114	1,405	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	1,127	12
13	Water Heater	2008	6,570		20	329	329	3,948	13
14	Handrails	2008	100,904		20	5,045	5,045	60,540	14
15	Electrical Work - Resident Rooms	2010	7,985		20	399	399	1,995	15
16	Wall Removal - 4th Floor Dining	2010	7,000		20	405	405	2,025	16
17	Outdoor Fence	2010	6,570		20	329	329	1,645	17
18	Kitchen Lighting	2010	8,026		20	803	803	4,015	18
19	Flooring - Carpet and Tile	2011	7,869		20	393	393	1,572	19
20	Fire-Sprinkler Heads	2011	2,790		20	140	140	560	20
21	Outdoor Facility Sign	2012	10,113		20	506	506	1,518	21
22	Compressor for Walk-in Freezer	2012	5,820		20	291	291	873	22
23	Dialysis Room-New: Construction, plumbing, HVAC & Electrical	2012	42,518		20	2,126	2,126	6,378	23
24	Nurse Call System	2012	7,800		20	390	390	1,170	24
25	Installed Amtico Flooring On 1st Floor Therapy Room	2013	9,999		20	500	500	1,000	25
26	Installed Cabintery, Countertop Finish & Molding in Physcial	2013	12,400		20	620	620	1,240	26
27	Installed Nurse Station	2013	25,000		20	1,250	1,250	2,500	27
28	Installed Elevator Panel	2013	8,000		20	400	400	800	28
29	Installed Cabintery	2013	5,000		20	250	250	500	29
30	Replacement Windows	2013	9,133		20	457	457	913	30
31	Install Flooring & Walls in Break Room & Adjoining Bathroom	2014	4,330		20	216	216	216	31
32	Building Company Depreciation			20,707			(20,707)		32
33									33
34	TOTAL (lines 1 thru 33)		$ 345,020	$ 20,707		$ 19,461	$ (1,246)	$ 140,884	34

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 12F, Carried Forward		$ 345,020	$ 20,707		$ 19,461	$ (1,246)	$ 140,884	1
2	Kitchen Floor Tile	2015	17,653		20	883	883	883	2
3	Asphalt & Concrete Work	2015	69,600		20	3,480	3,480	3,480	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)		$ 432,273	$ 20,707		$ 23,824	$ 3,117	$ 145,247	34

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$	$		$	$	$	1
2	Buildings:								2
3	Alloc. - S.I.R. Management	2009	26,673	684	39	684		4,132	3
4	Alloc. - S.I.R. Properties - S.I.R. Management	1993	24,148	767	35	690	(77)	15,524	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Alloc. - S.I.R. Management	1993	6,122	170	20		(170)	6,122	9
10	Alloc. - S.I.R. Management	1994	19		20			19	10
11	Alloc. - S.I.R. Management	1995	140		20	4	4	140	11
12	Alloc. - S.I.R. Management	1997	9,407	211	20	459	248	8,791	12
13	Alloc. - S.I.R. Management	1999	740		20	37	37	601	13
14	Alloc. - S.I.R. Management	1999			20				14
15	Alloc. - S.I.R. Management	2000	873		20	44	44	679	15
16	Alloc. - S.I.R. Management	2007	2,806		20	140	140	1,150	16
17	Alloc. - S.I.R. Management	2008	7,733	773	20	487	(286)	3,824	17
18	Alloc. - S.I.R. Management	2009	19,216	176	20	961	785	6,000	18
19	Alloc. - S.I.R. Management	2011	475	48	20	48		210	19
20	Alloc. - S.I.R. Management	2012	1,521	76	20	76		260	20
21	Alloc. - S.I.R. Management	2014	213	21	20	11	(10)	17	21
22									22
23	Alloc. - S.I.R. Properties - S.I.R. Management	2012	1,479	104	20	5	(99)	26	23
24	Alloc. - S.I.R. Properties - S.I.R. Management	2010	1,457		20	73	73	389	24
25	Alloc. - S.I.R. Properties - S.I.R. Management	2009	1,450	65	20	72	7	493	25
26	Alloc. - S.I.R. Properties - S.I.R. Management	2007	423	8	20	21	13	190	26
27	Alloc. - S.I.R. Properties - S.I.R. Management	2002	96		20	5	5	65	27
28	Alloc. - S.I.R. Properties - S.I.R. Management	1999	3,060		20	153	153	2,524	28
29	Alloc. - S.I.R. Properties - S.I.R. Management	1998	1,462		20	73	73	1,279	29
30	Alloc. - S.I.R. Properties - S.I.R. Management	1997	91		20	5	5	87	30
31	Alloc. - S.I.R. Properties - S.I.R. Management	1994	230	6	20		(6)	230	31
32	Alloc. - S.I.R. Properties - S.I.R. Management	1993	392		20			392	32
33									33
34	TOTAL (lines 1 thru 33)		$ 110,226	$ 3,109		$ 4,048	$ 939	$ 53,144	34

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 12H, Carried Forward		$ 110,226	$ 3,109		$ 4,048	$ 939	$ 53,144	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)		$ 110,226	$ 3,109		$ 4,048	$ 939	$ 53,144	34

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 895,289	$ 69,647	$ 89,787	$ 20,140	10	$ 467,467	71
72	Current Year Purchases	6,446		107	107	10	107	72
73	Fully Depreciated Assets	502,448		4	4	10	502,448	73
74								74
75	TOTALS	$ 1,404,183	$ 69,647	$ 89,898	$ 20,251		$ 970,023	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		2014 Ford Van	2014	$ 41,384	$ 4,138	$ 8,277	$ 4,139	5	$ 16,554	76
77		Allocated From SIR Management	2014	1,875	165	200	35	5	1,281	77
78										78
79										79
80	TOTALS			$ 43,259	$ 4,303	$ 8,477	$ 4,174		$ 17,835	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)	$ 7,042,068	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 296,094	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 294,829	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,265)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,453,906	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 2,513 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from SIR Management		$	$ 3,887	17
18					18
19					19
20					20
21	TOTAL		$	$ 3,887	21

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

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 181,344	$		$ 181,344	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			20,498			20,498	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			200,887			200,887	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				242,301		242,301	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			256,088		60,673	50,649		367,410	13
14	TOTAL			$ 256,088		$ 463,402	$ 292,950		$ 1,012,440	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.

STATE OF ILLINOIS

Facility Name & ID Number Rock Island Nursing And Rehab Center **#** 0049866 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/15 **(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	$ 8,084	$ 44,130	1
2	Cash-Patient Deposits	32,722	32,722	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,195,681	2,195,681	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,115	25,728	6
7	Other Prepaid Expenses	57,894	57,894	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		548,533	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,319,496	$ 2,904,688	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	789,994	1,151,052	15
16	Equipment, at Historical Cost	561,264	1,281,779	16
17	Accumulated Depreciation (book methods)	(759,926)	(1,705,743)	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):		1,077,473	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 591,332	$ 5,708,168	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,910,828	$ 8,612,856	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 310,707	$ 310,707	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,722	32,722	28
29	Short-Term Notes Payable	1,600,000	1,600,000	29
30	Accrued Salaries Payable	118,789	118,789	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,242	5,242	31
32	Accrued Real Estate Taxes(Sch.IX-B)		110,000	32
33	Accrued Interest Payable		14,155	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	10,000	10,000	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	154,480	154,480	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,231,940	$ 2,356,095	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,731,391	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43			10,543	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,741,934	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,231,940	$ 7,098,029	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 678,888	$ 1,514,827	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,910,828	$ 8,612,856	48

***(See instructions.)**

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 881,473	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 881,475	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(202,587)	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)**	$ (202,587)	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)**	$ 678,888	24 *

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

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 7,428,282	1
2	Discounts and Allowances for all Levels	(1,458,459)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,969,823	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,334,557	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,334,557	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	192	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	201,937	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	33,891	19
20	Radiology and X-Ray	2,775	20
21	Other Medical Services	165,552	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 404,347	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,472	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,472	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	278,931	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 278,931	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,990,130	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,319,794	31
32	Health Care	3,110,797	32
33	General Administration	1,767,929	33
	B. Capital Expense		
34	Ownership	668,817	34
	C. Ancillary Expense		
35	Special Cost Centers	1,012,440	35
36	Provider Participation Fee	312,940	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,192,717	40
41	**Income before Income Taxes (line 30 minus line 40)****	(202,587)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (202,587)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,243,354	44
45	Private Pay - Net Inpatient Revenue	179,936	45
46	Medicare - Net Inpatient Revenue	767,795	46
47	Other-(specify) Hospice	129,453	47
48	Other-(specify) Insurance/HMO/Managed Care	649,285	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,969,823	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.

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,989	2,086	$ 70,863	$ 33.97	1
2	Assistant Director of Nursing	182	352	9,340	26.53	2
3	Registered Nurses	11,559	12,336	315,894	25.61	3
4	Licensed Practical Nurses	32,335	34,038	660,443	19.40	4
5	CNAs & Orderlies	79,721	83,391	947,446	11.36	5
6	CNA Trainees					6
7	Licensed Therapist	9,469	9,893	256,088	25.89	7
8	Rehab/Therapy Aides	7,339	8,083	106,920	13.23	8
9	Activity Director					9
10	Activity Assistants	8,359	8,926	103,963	11.65	10
11	Social Service Workers	9,549	10,210	139,090	13.62	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,580	21,626	212,634	9.83	15
16	Dishwashers					16
17	Maintenance Workers	3,917	4,112	67,437	16.40	17
18	Housekeepers	14,844	15,223	142,227	9.34	18
19	Laundry	8,340	8,686	85,857	9.88	19
20	Administrator	1,994	2,166	94,288	43.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,945	9,440	142,253	15.07	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	5,557	6,095	107,466	17.63	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	224,679	236,663	$ 3,462,209 *	$ 14.63	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 21,255	01-03	35
36	Medical Director	Monthly	44,825	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	49,476	10-03	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	Monthly	9,580	10a-03	40
41	Occupational Therapy Consultant	Monthly	7,728	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	4,677	10a-03	43
44	Activity Consultant				44
45	Social Service Consultant	64	3,628	12-03	45
46	Other(specify) Dir. Of Food Service	Monthly	21,240	3-Jan	46
47	Specialized Services Consultant	Monthly	16,992	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	64	$ 179,401		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	436	$ 16,339	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	1,904	52,985	10-03	52
53	TOTAL (lines 50 - 52)	2,340	$ 69,324		53

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Elizabeth Webster	Administrator	0	$ 94,288
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 94,288

B. Administrative - Other

Description	Amount
SIR Management - Director of Administrative Services	$ 50,976
SIR Management - Ancillary Administrative Charges	42,480
TOTAL (agree to Schedule V, line 17, col. 3)	$ 93,456
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FRR/Marcum LLP	Accounting Services	$ 16,790
Plante & Moran	Accounting Services	4,475
McGladrey/RSM	Accounting Services	1,455
SIR Management	Dir. of Financial Services	39,600
SIR Management	Dir. of Regulatory Services	25,488
Personnel Planners	Unemployment Consultation	2,984
Legal Fees	See Attached	15,772
Achieve Accreditation	Accreditation	12,820
HK Payroll Services	Payroll	4,895
Pinnacle Quality Insights	Customer Satisfaction	2,223
E-Health	Data Processing	3,300
See Supplemental Schedule		140,785
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 270,586

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 69,584
Unemployment Compensation Insurance	41,637
FICA Taxes	259,565
Employee Health Insurance	72,241
Employee Meals	23,608
Illinois Municipal Retirement Fund (IMRF)*	
401K Matching Contributions	400
Other Employee Benefits	7,958
TOTAL (agree to Schedule V, line 22, col.8)	$ 474,993

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	14,875
Health Care Worker Background Check	
(Indicate # of checks performed 425)	4,250
Patient Background Checks	
Dues & Subscriptions	24,477
Licenses & Permits	3,151
Allocated from SIR Management	1,121
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 49,866

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,035
Allocated from SIR Management	813
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,848

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Rock Island Nursing And Rehab Center # 0049866 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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 - $24,664.70**

(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. $ **12,449** 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. $ **312,940**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **23,608** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **192**

(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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.