

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0022996 Facility Name: Iona Glos SLC Address: 50 South Fairbank StAddison60101 NumberCityZip Code County: Dupage Telephone Number: (630) 620-2222Fax # (630) 628-1488 HFS ID Number: Date of Initial License for Current Owners: November 18, 1980 Type of Ownership: X VOLUNTARY,NON-PROFIT X Charitable Corp. Trust IRS Exemption Code PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Jaime AlmonteTelephone Number: (630) 628-7260 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 07/01/2015 to 06/30/2016 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) (Type or Print Name) Carmel A. Cooke (Title) CFO Paid Preparer (Signed) (Print Name and Title) (Firm Name & Address) (Telephone) ()Fax # () MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 HFS 3745 (N-4-99) IL478-2471

Facility Name & ID Number Iona Glos SLC

0022996 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	100	Intermediate/DD	100	36,600	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,600	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	35,436	366		35,802	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,436	366		35,802	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.82%

D. How many bed-hold days during this year were paid by the Department? 429 (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES NO X

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

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

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

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

Medicare Intermediary

IV. ACCOUNTING BASIS

MODIFIED ACCRUAL X CASH* CASH*

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

Tax Year: June 30 Fiscal Year: June 30 * All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	145,517		34,877	180,394		180,394		180,394			1
2	Food Purchase		338,651		338,651		338,651		338,651			2
3	Housekeeping	3,964	156,226	81,198	241,388		241,388	(44,958)	196,430			3
4	Laundry											4
5	Heat and Other Utilities			118,800	118,800		118,800	(131)	118,669			5
6	Maintenance	221,312	117,383		338,695		338,695	(1,246)	337,449			6
7	Other (specify):* waste removal			19,675	19,675		19,675		19,675			7
8	TOTAL General Services	370,793	612,260	254,550	1,237,603		1,237,603	(46,335)	1,191,268			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	962,012	106,800		1,068,812		1,068,812		1,068,812			10
10a	Therapy	1,275,828			1,275,828		1,275,828		1,275,828			10a
11	Activities		31,610		31,610		31,610		31,610			11
12	Social Services	43,776			43,776		43,776		43,776			12
13	CNA Training	16,313	650		16,963		16,963		16,963			13
14	Program Transportation			40,576	40,576		40,576		40,576			14
15	Other (specify):* license/certif & sch XVIII			39,385	39,385		39,385		39,385			15
16	TOTAL Health Care and Programs	2,297,929	139,060	79,961	2,516,950		2,516,950		2,516,950			16
	C. General Administration											
17	Administrative	819,040			819,040		819,040	(38,232)	780,808			17
18	Directors Fees											18
19	Professional Services			50,155	50,155		50,155	(14,062)	36,093			19
20	Dues, Fees, Subscriptions & Promotions			24,868	24,868		24,868	(1,427)	23,441			20
21	Clerical & General Office Expenses	334,444	58,595		393,039	(13,276)	379,763	(4,907)	374,856			21
22	Employee Benefits & Payroll Taxes			885,127	885,127		885,127	(5,245)	879,882			22
23	Inservice Training & Education			6,263	6,263		6,263		6,263			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			1,903	1,903		1,903	(302)	1,601			25
26	Insurance-Prop.Liab.Malpractice			53,566	53,566		53,566		53,566			26
27	Other (specify):* Bank Charges			77,414	77,414		77,414	(69,011)	8,403			27
28	TOTAL General Administration	1,153,484	58,595	1,099,296	2,311,375	(13,276)	2,298,099	(133,186)	2,164,913			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,822,206	809,915	1,433,807	6,065,928	(13,276)	6,052,652	(179,521)	5,873,131			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			366,599	366,599		366,599	(4,458)	362,141			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			348	348		348	(348)				33
34	Rent-Facility & Grounds			84,551	84,551	13,276	97,827	(5,749)	92,078			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			451,498	451,498	13,276	464,774	(10,555)	454,219			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			335,185	335,185		335,185		335,185			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			335,185	335,185		335,185		335,185			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,822,206	809,915	2,220,490	6,852,611		6,852,611	(190,076)	6,662,535			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,458)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(13,655)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,931)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(166,032)	pg5A		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (190,076)		\$	30

BHF USE ONLY							
48		49		50		51	
						52	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (190,076)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Adjustment for Fundraising = 50% of Development	\$		1
2	also see Worksheet 1			2
3				3
4	Supplies	(44,958)	3	4
5	Utilities	(131)	5	5
6	Maintenance	(1,210)	6	6
7	Administrative	(38,232)	17	7
8	Software Maintenance	(407)	19	8
9	Marketing Materials	(855)	20	9
10	Networking	(191)	20	10
11	Memberships	(373)	20	11
12	Publications	(8)	20	12
13	Clerical & General Office	(4,907)	21	13
14	Employee Benefits & Payroll Taxes	(5,245)	22	14
15	Travel	(302)	25	15
16	Insurance	(36)	6	16
17	Bank Charges	(2,211)	27	17
18	Rent	(5,749)	34	18
19	Total fundraising adjustment			19
20	(104,815)			20
21				21
22	Other non allowables & adjustments			22
23	Agency Functions	(60,718)	27	23
24	Fines, penalties & late fees	(151)	27	24
25	Real Estate Taxes	(348)	33	25
26	Total Other Non allowable adjustments			26
27	(61,217)			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	(166,032)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Iona Glos SLC

0022996

Report Period Beginning:

07/01/2015

Ending:

06/30/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	(44,958)	0	0	0	0	0	0	0	0	0	0	(44,958)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(131)	0	0	0	0	0	0	0	0	0	0	(131)	5
6	Maintenance	(1,246)	0	0	0	0	0	0	0	0	0	0	(1,246)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(46,335)	0	0	0	0	0	0	0	0	0	0	(46,335)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(38,232)	0	0	0	0	0	0	0	0	0	0	(38,232)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(14,062)	0	0	0	0	0	0	0	0	0	0	(14,062)	19
20	Fees, Subscriptions & Promotions	(1,427)	0	0	0	0	0	0	0	0	0	0	(1,427)	20
21	Clerical & General Office Expenses	(4,907)	0	0	0	0	0	0	0	0	0	0	(4,907)	21
22	Employee Benefits & Payroll Taxes	(5,245)	0	0	0	0	0	0	0	0	0	0	(5,245)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(302)	0	0	0	0	0	0	0	0	0	0	(302)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(69,011)	0	0	0	0	0	0	0	0	0	0	(69,011)	27
28	TOTAL General Administration	(133,186)	0	0	0	0	0	0	0	0	0	0	(133,186)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(179,521)	0	0	0	0	0	0	0	0	0	0	(179,521)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(4,458)	0	0	0	0	0	0	0	0	0	0	(4,458)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(348)	0	0	0	0	0	0	0	0	0	0	(348)	33
34	Rent-Facility & Grounds	(5,749)	0	0	0	0	0	0	0	0	0	0	(5,749)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(10,555)	0	0	0	0	0	0	0	0	0	0	(10,555)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(190,076)	0	0	0	0	0	0	0	0	0	0	(190,076)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Not for Profit Corp - board members DO NOT have ownership in Ray Graham Association						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		N/A	\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

Facility Name & ID Number

Iona Glos SLC

0022996

Report Period Beginning:

07/01/2015

Ending:

06/30/2016

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	page 29 for addresses and other details							1
2	Chairperson - Neville Bilimoria	BOD						2
3	Vice Chair - Lee Jorwic	BOD						3
4	Secretary/Treasurer - Jeff Park	BOD						4
5	Immediate Past Chair - Michael Komoll	BOD						5
6								6
7	Members at Large							7
8	Executive/Nominating Committee -							8
9	Lou Leonardi	BOD						9
10	Jonathan Phillips	BOD						10
11	Mary Alice Povolny - PhD	BOD						11
12	Michael Booth	BOD						12
13	John N. DeFranco	BOD						13
14	Joseph Derezinski	BOD						14
15	Russell Frees	BOD						15
16	Mark E. Kroencke	BOD						16
17	Teri Litavsky	BOD						17
18	Mary Kay Rizzolo Mann	BOD						18
19	Chris Schneider, CIMA	BOD						19
20	Cami Smith	BOD						20
21	Robert F. Spahn Jr	BOD						21
22	Stephanie Stomberg	BOD						22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NONE								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: 07/01/2015 Ending: 6/30/2016

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1		see worksheet 1	direct costs			\$	\$		\$ 970,923	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					\$	\$		\$ 970,923	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	N/A						\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	N/A												6
7													7
8													8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10	N/A												10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Zero Line # N/A

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2011		8	
	2012		9	
	2013		10	
	2014		11	
	2015		12	
		FOR BHF USE ONLY		
		13	FROM R. E. TAX STATEMENT FOR 2015 \$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Iona Glos SLC COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0022996

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 47,000

B. General Construction Type: Exterior brick Frame Number of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

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

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	SLC		1975	\$ 214,674	1
2					2
3	TOTALS			\$ 214,674	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	100		1980	1980	\$ 3,681,931	\$ 92,048	40	\$ 92,048		\$ 3,267,714
5										
6										
7										
8										
	Improvement Type**									
9	SLC DIRECT									
10	Prior Fiscal Years			2007	88,153	8,815	10	8,815		74,930
11				2008	407,142	40,714	10	40,714		323,836
12				2009	143,794	14,379	10	14,379		100,446
13				2010	61,179	6,118	10	6,118		39,766
14				2011	519,054	53,085	10	53,085		289,607
15				2012	362,053	37,926	5	37,926		169,631
16	Commercial Water Heater - House 4			2013	5,280	528	10	528		1,344
17	Compressor Repairs			2013	3,420	684	5	684		1,710
18	Changing room/ Sheds/ Conf. Room/ Nurses Office			2013	626	125	5	125		313
19	Boiler - Replacement Parts			2013	19,041	3,808	5	3,808		9,521
20	Repairs to Front Awning			2013	1,879	376	5	376		939
21	Water Heater			2013	5,020	1,004	5	1,004		2,510
22	Wall Heating Unit - SLC Activity Room			2014	10,060	2,012	5	2,012		5,198
23	Water Heater - Home 1			2014	1,540	308	5	308		770
24	Bradford Water Heater - Home 3			2014	3,190	638	5	638		1,595
25	6 Fire Rated Doors			2014	4,738	948	5	948		2,369
26	Bathroom Flooring Repairs - Home 2 & 4			2014	13,350	1,335	10	1,335		3,338
27	Parking lot Timer for parking lot lights replaced			2014	1,884	377	5	377		565
28	Flooring Repairs in Home 1,3,5 to solve tripping hazardz			2014	5,380	1,076	5	1,076		1,614
29	Door Replacements Home 1 & Home 3			2015	3,416	683	5	683		1,025
30	Automatic Fire Alarm System			2015	4,408	882	5	882		1,322
31	AC Damper Motor Replaced			2015	1,058	212	5	212		317
32	Complete Kitchen Renovations in 6 homes -new flooring,			2015	255,294	25,529	10	25,529		38,294
33	cabinets, countertops, sinks, faucets, garbagr disposals,									
34	light fixtures, interior and exterior kitchen doors, painting									
35										
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Iona Glos SLC

0022996

Report Period Beginning:

07/01/2015 Ending: 06/30/2016

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Airconditioning unit Home 5	2015	\$ 3,069	\$ 307	5	\$ 307	\$	\$ 307	37
38	Gas Regulator Home 5	2015	571	57	5	57		57	38
39	Bradford 100 Gal Water Heater Home 2	2015	7,490	749	5	749		749	39
40	AC Condensing Unit Home 4	2015	3,274	328	5	328		328	40
41	Dumpter Concrete Pad	2015	2,876	287	5	287		287	41
42	Bathtub Control motor	2015	1,261	126	5	126		126	42
43	Transitional Floorings on entry way Home 4	2015	643	64	5	64		64	43
44	New Insulation for Dryer Install	2015	655	66	5	66		66	44
45	Hot Water Circulator Pump	2016	508	51	5	51		51	45
46	Outdoor Reset Control for Boiler	2016	1,152	115	5	115		115	46
47	Bradford 75 gal Water Heater H4	2016	1,764	176	5	176		176	47
48	Homes 1 & 2 & Core Building Bathroom Renovation	2016	191,845	9,592	10	9,592		9,592	48
49	Removed existing tile walls, wall base, corner guards and substrate								49
50	Removed shower bases, hand towel dispensers, soap dispensers, toilet dispensers								50
51	countertops/sink. Removed mirrord, grab bars, floorings, wall mounted fixtures and ceiling mounted ventilation fans/lights.								51
52	Replaced substrate walls and floors. Replaced shower walls and ceilings.								52
53	Replaced toilets, replaced faucets, replaced shower benches.								53
54	Replaced and added grab bars in showers, st toilet and at hand washing sink								54
55	Replaced door handles. Touched up wooden doors, stain & varnish.								55
56	Replaced light fixtures and ventilation fans.								56
57	Replaced mirrors, replaced tolet shut off valves.								57
58	Painted related areas.								58
59									59
60									60
61									61
62									62
63									63
64									64
65	Fully Depreciated Assets								65
66	SLC Direct - Building Improvements		1,145,770	1,990		1,990		1,145,088	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,963,768	\$ 307,518		\$ 307,518	\$	\$ 5,495,680	70

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

Facility Name & ID Number Iona Glos SLC

0022996

Report Period Beginning:

07/01/2015 Ending: 06/30/2016

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		\$ 6,963,768	\$ 307,518		\$ 307,518	\$	\$ 5,495,680	1
2									2
3	EQUIPMENT DEPRECIATION								3
4									4
5	Purchase in Prior Years								5
6	SLC Direct - FFE		81,314	21,081		21,081		58,366	6
7									7
8	Management & General								8
9	Administration - FFE		37,893	4,650		4,650		37,665	9
10	SLC portion of Administration - 29.58%		11,210	1,376		1,376		17,860	10
11									11
12	Human Resources FFE		1,647	549		549		1,419	12
13	SLC portion of HR - 29.76%		490	163		163		422	13
14									14
15	Finance FFE		61,486	11,863		11,863		48,253	15
16	SLC portion of Finance - 29.66%		18,234	3,518		3,518		14,309	16
17									17
18	Total Depreciation Expense Purchase in Prior Years		111,248	26,138		26,138		90,957	18
19									19
20	Current Fiscal Year Purchases								20
21	SLC Direct - FFE								21
22	Electric Can Opener	2015	647	65	5	65		65	22
23	Desk for Directors office	2015	749	75	5	75		75	23
24	Amana Washer - Home 5	2015	510	85	3	85		85	24
25	Amana Dryer - Home 6	2015	580	97	3	97		97	25
26	Amana Washer - Home 4	2015	510	85	3	85		85	26
27	Two Drawer Chest Core Building	2015	679	113	3	113		113	27
28	6 - Remy Bariatric Armchairs	2015	2,695	449	3	449		449	28
29	2 - Super Capacity Dryers Core Building	2015	9,893	989	5	989		989	29
30	2 Flexsteel Recliners	2015	1,226	204	3	204		204	30
31	Total FFE SLC Direct this page		17,488	2,162		2,162		2,162	31
32									32
33	REVERSE EVERYTHING AND PICK UP BLDG IMPROVEMENTS ONLY		(358,499)	(73,662)		(73,662)		(273,575)	33
34	TOTAL (lines 1 thru 33)		\$ 6,963,768	\$ 307,518		\$ 307,518	\$	\$ 5,495,680	34

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

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 6,963,768	\$ 307,518		\$ 307,518	\$	\$ 5,495,680	1
2 REVERSE ABOVE BECAUSE THIS REALLY IS 13A		(6,963,768)	(307,518)		(307,518)		(5,495,680)	2
3 EQUIPMENT DEPRECIATION DETAIL CONTINUATION FROM PG12B								3
4								4
5 Computer Case Home 4	2015	928	155	3	155		155	5
6 Computer Cases Home 1,2,3,5,6	2016	5,000	833	3	833		833	6
7 4 Recliners	2016	2,969	495	3	495		495	7
8 Food Processor with extra bowls	2016	759	126	3	126		126	8
9 Furniture all homes	2016	14,360	2,393	3	2,393		2,393	9
10 Transfer Switch for Generator	2016	4,484	448	3	448		448	10
11 5 Dell Computers	2016	3,587	598	3	598		598	11
12 Rational Combi Oven	2016	14,474	1,447	5	1,447		1,447	12
13 Total FFE SLC Direct this page		46,561	6,496		6,496		6,496	13
14								14
15 Finance - Current Year Purchases								15
16 Watchguard Firewall	2016	2,814	469	3	469		469	16
17 14 Samsung LED Computer Monitors	2016	3,724	623	3	623		623	17
18 Total Finance FFE Current Year Purchases		6,538	1,092		1,092		1,092	18
19 SLC portion of Finance - 29.66%		1,939	324		324		324	19
20								20
21 Total Current Year Purchases		65,989	8,982		8,982		8,982	21
22 Reflects line 13 & 19 this page and line 31 pg 12B								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33 REVERSE EVERYTHING AND PICK UP BLDG IMPROVEMENTS ONLY		6,789,642	283,035		283,035		5,471,197	33
34 TOTAL (lines 1 thru 33)		\$ 6,963,768	\$ 307,518		\$ 307,518	\$	\$ 5,495,680	34

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

Facility Name & ID Number Iona Glos SLC

0022996

Report Period Beginning:

07/01/2015

Ending:

06/30/2016

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		\$ 6,963,768	\$ 307,518		\$ 307,518	\$	\$ 5,495,680	1
2	REVERSE ABOVE BECAUSE THIS REALLY IS 13A		(6,963,768)	(307,518)		(307,518)		(5,495,680)	2
3	EQUIPMENT DEPRECIATION DETAIL CONTINUATION FROM PG12C								3
4									4
5	Fully Depreciated Assets - FFE								5
6	SLC Direct		120,387	717		717		717	6
7									7
8	Management & General								8
9	Administration - FFE		22,704						9
10	SLC portion of Administration - 29.58%		6,717						10
11									11
12	Human Resources FFE		6,890						12
13	SLC portion of HR - 29.76%		2,050						13
14									14
15	Finance FFE		84,090						15
16	SLC portion of Finance - 29.66%		24,937						16
17									17
18	Development FFE		5,235						18
19	SLC portion of Development - 32.55%		1,704						19
20									20
21	Total Fully Depreciated Assets		155,795	717		717		717	21
22	Reflects lines 06,10,13,16 & 19 pg12D								22
23									23
24	TOTAL DEPRECIATION EXPENSE - EQUIPMENT		333,032	35,837		35,837		35,837	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33	REVERSE EVERYTHING AND PICK UP BLDG IMPROVEMENTS ONLY		6,200,227	270,247		270,247		5,458,409	33
34	TOTAL (lines 1 thru 33)		\$ 6,963,768	\$ 307,518		\$ 307,518	\$	\$ 5,495,680	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$111,248	\$26,138	\$26,138	\$		\$90,957	71
72	Current Year Purchases	65,989	8,982	8,982			8,982	72
73	Fully Depreciated Assets	155,795	717	717				73
74								74
75	TOTALS	\$333,032	\$35,837	\$35,837	\$		\$99,939	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	client transportation	Ford Eldorado AeroTech 220	2011	\$57,746	\$5,775	\$5,775	\$	5	\$57,746	76
77	client transportation	Dodge Gran Caravan	2013	36,672	7,335	7,335		5	18,336	77
78	client transportation	2016 Ford Starcraft	2016	56,755	5,676	5,676		5	5,676	78
79										79
80	TOTALS			\$151,173	\$18,786	\$18,786	\$		\$81,758	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)	\$7,662,647	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$362,141	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$362,141	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$5,677,377	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: MillBrook Real Estate - see worksheet 7
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:		N/A		\$ 78,802	10		3
4	Additions							4
5								5
6								6
7	TOTAL				\$ 78,802			7

8. List separately any amortization of lease expense included on page 4, line 34.
- This amount was calculated by dividing the total amount to be amortized
- by the length of the lease
-

9. Option to Buy:
- ☐ YES
- ☒ NO
- Terms:
-
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO
16. Rental Amount for movable equipment: \$ 13,276
- Description: see worksheet 8
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 03/2011

Ending 12/2021

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

	Fiscal Year Ending	Annual Rent
12.	<u>06/30/2017</u>	\$ <u>41,349</u>
13.	<u>06/30/2018</u>	\$ <u>42,986</u>
14.	<u>06/30/2019</u>	\$ <u>44,624</u>

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☒ YES

☐ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

40

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

80

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies	200	450		650
3	Classroom Wages (a)	2,412	7,282		9,694
4	Clinical Wages (b)	711	1,098		1,809
5	In-House Trainer Wages (c)	1,480	3,330		4,810
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 4,803	\$ 12,160	\$	\$ 16,963
10	SUM OF line 9, col. 1 and 2 (e)	\$ 16,963			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	18
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	8
2. From other facilities (f)	
TOTAL TRAINED	26

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	N/A	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	N/A	hrs							2
3	Licensed Recreational Therapist	N/A	hrs							3
4	Licensed Physical Therapist	N/A	hrs							4
5	Physician Care	N/A	visits							5
6	Dental Care	N/A	visits							6
7	Work Related Program	N/A	hrs							7
8	Habilitation	N/A	hrs							8
9	Pharmacy	N/A	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	N/A	hrs							10
11	Academic Education	N/A	hrs							11
12	Other (specify):	N/A								12
13	Other (specify):	N								13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 8,227,356	\$	1
2	Cash-Patient Deposits	185,692		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 33,901)	3,195,525		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	249,370		5
6	Prepaid Insurance	215,534		6
7	Other Prepaid Expenses	5,822		7
8	Accounts Receivable (owners or related parties)	17,136		8
9	Other(specify):	26,046		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 12,122,481	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,784,867		12
13	Land	1,506,314		13
14	Buildings, at Historical Cost	11,120,173		14
15	Leasehold Improvements, at Historical Cost	9,190,842		15
16	Equipment, at Historical Cost	2,732,287		16
17	Accumulated Depreciation (book methods)	(16,265,205)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 11,069,278	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 23,191,759	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,160,798	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	189,188		28
29	Short-Term Notes Payable	64,151		29
30	Accrued Salaries Payable	549,887		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,256		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	10,624		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	deferred income	49,682		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,040,586	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,167,254		39
40	Mortgage Payable	2,013,271		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,180,525	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,221,111	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 13,970,648	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 23,191,759	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(175,803)	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)	\$ (175,803)	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)	\$ (175,803)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Iona Glos SLC

0022996

Report Period Beginning: 07/01/2015

Ending: 06/30/2016

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,818,316	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,818,316	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	76,491	10
11	CNA Training Reimbursements	34,276	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 110,767	23
	D. Non-Operating Revenue		
24	Contributions	521,951	24
25	Interest and Other Investment Income***	35,209	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 557,160	26
	E. Other Revenue (specify).****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Other: consulting</u>	489	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 489	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,486,732	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,191,304	31
32	Health Care	2,516,950	32
33	General Administration	2,164,877	33
	B. Capital Expense		
34	Ownership	454,219	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	335,185	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,662,535	40
41	Income before Income Taxes (line 30 minus line 40)**	(175,803)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (175,803)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 5,818,316	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,818,316	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,767	2,095	\$ 73,670	\$ 35.16	1
2	Assistant Director of Nursing	394	402	12,058	30.00	2
3	Registered Nurses	8,245	9,213	262,262	28.47	3
4	Licensed Practical Nurses	14,493	16,506	407,409	24.68	4
5	CNAs & Orderlies					5
6	CNA Trainees	1,165	1,165	16,313	14.00	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	1,860	2,112	43,776	20.73	11
12	Dietician					12
13	Food Service Supervisor	1,679	2,084	40,504	19.44	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,212	9,634	105,013	10.90	15
16	Dishwashers					16
17	Maintenance Workers	9,928	9,928	221,312	22.29	17
18	Housekeepers	373	373	3,964	10.63	18
19	Laundry					19
20	Administrator	1,037	1,415	59,256	41.88	20
21	Assistant Administrator	3,086	3,779	95,474	25.26	21
22	Other Administrative	22,736	27,246	473,229	17.37	22
23	Office Manager					23
24	Clerical	1,866	2,221	38,583	17.37	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	10,074	11,880	206,613	17.39	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	93,617	102,121	1,275,828	12.49	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>see worksheet 2</u>	12,629	14,082	486,942	34.58	33
34	TOTAL (lines 1 - 33)	193,161	216,256	\$ 3,822,206 *	\$ 17.67	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	646	\$ 34,877		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>psychologist/behavior</u>	58	13,345		46
47	<u>physician</u>	monthly	24,000		47
48	<u>Optometric</u>	68	2,040		48
49	TOTAL (lines 35 - 48)	772	\$ 74,262		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

[illegible]

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

(1)

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

NO

(2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

NO

(3)

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

NO

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

NO

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

YES
5 YEARS

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.
\$ 28,689 Line 10

(7)

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

YES

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

NO

(9)

Are you presently operating under a sublease agreement?

YES X NO

(10)

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

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 335,185

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

NO

(13)

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

N/A

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
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.

NO

(15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$ N/A
Indicate the amount. \$

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

NO

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
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?

N/A

d.

Have vehicle usage logs been maintained?

e.

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

YES

f.

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

N/A

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

NO
\$

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

YES
Porte Brown, LLC

(18)

Have all costs which do not relate to the provision of long term care been adjusted 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.
Attach invoices and a summary of services for all architect and appraisal fees

N/A

HFS 3745 (N-4-99)

IL478-2471

Worksheet 2 - page 1

Management and General Allocated Salaries:

	Management & General				SLC				Schedule V Reference
	# of Hrs. Actually Worked	# of Hrs. Report Period Paid and Total Salaries, Accrued	Wages	Percent	# of Hrs. Actually Worked	# of Hrs. Report Period Paid and Total Salaries, Accrued	Wages		
Administrators	5,262	6,274	387,427	30%	1,557	1,856	114,617	17	
Accounting/Bookkeeping	15,854	18,911	666,742	30%	4,702	5,608	197,723	21	
Human Resources	10,642	12,113	298,074	30%	3,167	3,605	88,700	21	
Development	8,434	7,423	234,913	33%	2,745	2,416	76,464	17	
Secy & Clerical	1,551	2,018	31,899	30%	459	597	9,437	21	
M&G Salaries per worksheet 1	41,743	46,739	1,619,056		12,629	14,082	486,942		
<u>Non-Allowables:</u>									
P.R. & Development	(4,217)	(3,712)	(117,457)	33%	(1,373)	(1,208)	(38,232)	17	
	(4,217)	(3,712)	(117,457)		(1,373)	(1,208)	(38,232)		
Net Allocated	37,526	43,028	1,501,600		11,257	12,874	448,710		

Management and General Allocated Salaries:
Detail of Salaries Paid to Administrators and Accounting/Bookkeeping

Administrators:

Employee Name	Title		Amount		
Musembi, Caren	Chief Services Officer	30%	1,812	2,141	139,938
Anderson, Sharon	Quality Enhancement Manager	30%	1,702	2,033	65,707
Zoeller, Kimberly	President/CEO	30%	1,748	2,100	181,228
	Allocated thru Building Maintenance				554
			5,262	6,274	387,427

Accounting/Bookkeeping:

Employee Name	Title		Amount		
Almonte, Jaime	Senior Accountant	30%	1,640	2,075	51,775
Brazzale, Tiana	Grants Administrator	30%	1,881	2,147	76,286
Cooke, Carmel	Chief Financial Officer	30%	1,711	2,104	172,407
Eklin, Kelsey	Staff Accountant	30%	1,944	2,137	48,058
Greenbeck, Leah	Controller	30%	1,861	2,139	80,683
Gurgone, Linda	Director Purchasing & Maintenance	30%	226	226	12,274
Horgan, Frances	Payroll Coordinator	30%	417	631	14,624
Maitha, Katherine	Payroll Coordinator	30%	1,276	1,584	39,247
Robinson, Sherry	Staff Accountant & Accounts Payable	30%	1,351	1,678	38,350
Tomczak, Irene	Accounts Receivable Coordinator	30%	1,750	2,055	39,215
Vidmar, James	System Administrator	30%	1,799	2,135	93,702
	Allocated thru Building Maintenance				121
			15,854	18,911	666,742

Worksheet 3

Detail of Other Expense on Schedule V. line 27

Management & General

allocated from Administration

bank fees	Finance	20,885	
	SLC alloc	<u>29.7%</u>	6,193
	Fundraising	13,582	
	SLC alloc	<u>32.5%</u>	4,421
		50% adjust	<u>(2,211)</u>
			2,210
Total Expense			<u><u>8,403</u></u>

Detail of Reclassifications on Schedule V. column 5

Description	To	From	Amount
equipment maintenance coded with equipment rental	line 35	line 21	13,276

Worksheet 7
Detail for Schedule XII. Rental Costs
Part A. Building and Fixed Equipment, No. 1 - 14

Line 3 - MillBrook Real Estate
Building - 901 Warrenville Rd, #500, Lisle,

Monthly Amount per Rent Agreement	03/01/15-02/28/16	12,881
	03/01/16-02/28/17	13,418
	03/01/17-02/28/18	13,954
	03/01/18-02/28/19	14,491
	03/01/19-02/28/20	15,028

plus, operating expenses & common area lighting
charges = 139,312

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

11 Rent to be paid in future years under the current rental agreement		
Fiscal Year Ending	Annual Rent	
12	06/30/2017	41,349
13	06/30/2018	42,986
14	06/30/2019	44,624
15	06/30/2020	46,262

RGA			SLC		
FY16 Rent	Division	Allocation	Amount	Allocation	Amount
156,719	Administration	21.27%	69,256	29.58%	20,489
	Life's Plan	8.85%	14,396		
	Human Resources	17.07%	56,986	29.76%	16,958
	Development	12.00%	35,322	32.55%	11,497
	Development fundraising adj				(5,749)
	Finance	40.81%	120,071	29.66%	35,607
		100.00%	296,031		78,802

FY17 Rent	Division	Allocation	Amount	Allocation	Amount
162,623	Administration	21.27%	34,586	29.58%	10,232
	Life's Plan	8.85%	14,396		
	Employee Services	17.07%	27,756	29.76%	8,260
	Advancement	12.00%	19,522	32.55%	6,354
	Advancement fundraising adj		0		(3,177)
	Finance	40.81%	66,362	29.66%	19,680
		100.00%	162,622		41,349

RGA			SLC		
FY18 Rent	Division	Allocation	Amount	Allocation	Amount
169,063	Administration	21.27%	35,955	29.58%	10,637
	Life's Plan	8.85%	14,966	0.00%	0
	Employee Services	17.07%	28,856	29.76%	8,587
	Advancement	12.00%	20,296	32.55%	6,606
	Advancement fundraising adj		0		(3,303)
	Finance	40.81%	68,990	29.66%	20,459
		100.00%	169,063		42,986

RGA			SLC		
FY19 Rent	Division	Allocation	Amount	Allocation	Amount
175,504	Administration	21.27%	37,325	29.58%	11,042
	Life's Plan	8.85%	15,536		
	Employee Services	17.07%	29,955	29.76%	8,914
	Advancement	12.00%	21,069	32.55%	6,858
	Advancement fundraising adj		0		(3,429)
	Finance	40.81%	71,619	29.66%	21,239
		100.00%	175,504		44,624

RGA			SLC		
FY20 Rent	Division	Allocation	Amount	Allocation	Amount
181,944	Administration	21.27%	38,695	29.58%	11,448
	Life's Plan	8.85%	16,106		0
	Employee Services	17.07%	31,054	29.76%	9,241
	Advancement	12.00%	21,842	32.55%	7,110
			0		(3,555)
	Finance	40.81%	74,247	29.66%	22,018
		100.00%	181,945		46,262

Worksheet 9

Detail for Schedule XIX. part A. Administrative Salaries

Name	Function	% Ownership	SLC Amount
Direct Staff			
1 Rau, Denise	SLC Director		59,256
2 Enverga, Nicole	Assistant Director		47,518
2 Halden, Erin	Assistant Director		47,956
3 Hickey-Scaccia, Marianne	Quality Enhancement Facilitator		49,455
3 Badalamenti, Salvatore	Coordinator		40,212
4 Davis, Zita	Coordinator		474
4 Harris, Deanna	Coordinator		55,463
5 Kachhawala, Zainab	Coordinator		38,099
5 Patel, Janki	Coordinator		35,493
6 Ugwoke, Innocent	Coordinator		30,284
6 Bruce, Pamela	Home Manager		38,089
7 Bush, Casey	Home Manager		18,379
7 Hamgeri, Angela	Home Manager		32,756
8 Tinsley, Shanta	Home Manager		33,457
8 Rusthoven, Adam	Home Manager		31,250
12 Cannon, Ryan	Assistant Home Manager		28,710
13 Patel, Ushma	Lead Home Manager		41,108
total SLC direct		100%	627,959
Management and General Allocated			
Administrators			
Musembi, Caren	Chief Services Officer		139,938
Anderson, Sharon	Quality Enhancement Manager		65,707
Zoeller, Kimberly	President		181,228
	Allocated thru Building Maintenance		554
SLC allocation		30%	387,427
Development			
Nagle, Lorraine	Chief Development Officer		110,532
Hennessy, Kelly	Communications Coordinator		10,547
Stillman-Wagstaff, Margaret	Donor Data Mgr & Strategist		44,367
Fillipp, Lynda	Marketing and Communications Coordinator		18,419
Janus, Noe	Special Events Manager		50,953
	Allocated thru Building Maintenance		95
SLC allocation		33%	234,913
Total Administrative Salaries reported on Schedule 5, Line 17, Column 1			819,040

Ray Graham Association Board of Directors FY 2016		
Officer	Residence	Business
Chairperson		
Neville Bilenoria Executive/Nominating Committee	2515 Chestnut Ave. Glenview, IL 60026 (847) 486-1868 nbilencia@duanemorris.com	Attorney Duane Morris 190 S. LaSalle St. #3700 Chicago, IL 60603 (312) 499-6758
Vice-Chairperson		
Lee Jonvic Executive/Nominating Committee Advocacy Committee	375 S Kentworth Elmhurst, IL 60126 (630) 624-0967 jonvic@411njjonvic.com	President Klart-Jonvic & Associates 127 W Wrightwood Elmhurst, IL 60126 (630) 833-4193
Secretary/Treasurer		
Jeff Pask Finance Committee	2108 Primrose Lane Naperville, IL 60565 (630) 536-8592 jeff.pask@pac.com	CFO Catamaran 1600 McConnor Parkway Schaumburg, IL 60179-6801 (224) 231-3295
Immediate Past Chairperson		
Michael Komolli Executive/Nominating Committee	3420 Richnee Lane Rolling Meadows, IL 60008 michael.komolli@cna.com	Assistant Vice President - Major Litigation C.N.A Insurance 333 S. Wabash, 275/29-1 Chicago, IL 60685 (312) 822-2816
Member-at-Large		
Lou Leonard III Executive/Nominating Committee Finance Committee	609 Ashland River Forest, IL 60305 lleonard@thebeverlybank.com	The Beverly Bank 10258 S. Western Avenue Chicago, IL 60643 (773) 239-2265
Member-at-Large		
Jonathan Phillips Executive/Nominating Committee Finance Committee	792 Chatham Avenue Elmhurst, IL 60126 (312) 276-5180 jg@healthcaregrowth.com	Managing Director Healthcare Growth Partners 792 Chatham Avenue Elmhurst, IL 60126 (630) 530-4420
Member-at-Large		
Mary Alice Povorny, Ph.D Executive/Nominating Committee	633 Monroe Street River Forest, IL 60305 (708) 366-6963 (708) 790-2371 m.povorny@att.net	Clinical Psychologist 188 Industrial Park, Ste 132 Elmhurst, IL 60126 (630) 415-0780
Director		
Michael Booth Development Committee	379 E Parkview Avenue Elmhurst, IL 60126 (630) 634-4686 (h) (630) 776-1973 (cp) Michael.Booth@comcast.net	President Mid American Group 760 Pasquetti Drive, Suite 358 Westmont, IL 60559 (630) 366-7444
Director		
John N. DeFranco, MD Advocacy Committee	8019 W 124th Street Palos Park, IL 60464 (708) 671-0856 (h) jn483@gmail.com	Partner Associated Urologic Specialists 10400 Southwest Highway Chicago Ridge, IL 60415 (708) 425-8786
Director		
Joseph Derezinski Development Committee	236 S. Bodin St. Hinsdale, IL (630) 734-9471 (h) (312) 461-3146 (cp)	Sr. Vice President Harris Bank 111 W. Monroe St. 5C Chicago, IL 60603 joseph.derezinski@harrisbank.com
Director		
Russell Frees Development Committee	900 W Porter Avenue Naperville, IL 60540 (630) 527-8720 (h) (630) 638-7333 © r.frees@henricksen.com	Executive Vice President 328 S Jefferson Avenue Chicago, IL 60661 (312) 669-9090
Director		
Mark E. Kroencke Finance Committee	4000 Peartree Drive Lake in the Hills, IL 60156 (847) 875-8967	Vice President First American Bank 1650 Louis Avenue Elk Grove Village, IL 60007 (847) 588-2242 mikroencke@firstbank.com
Director		
Teri Litavsky Development Committee	225 N. Elm Avenue Elmhurst, IL 60126 (630) 834-6612 (h) (630) 217-6610 cell	Owner/Artist Wild Bird Pottery Studio 101 N. Addison Street Elmhurst, IL 60126
Director		
Mary Kay Rizzolo Mann Strategic Planning Public Policy Committee	1713 W. Schubert Avenue Chicago, IL 60614 (773) 868-0263 Mrizzolo@uic.edu	Clinical Associate Professor University of IL at Chicago Associate Director of Institute on Disability and Human Development
Director		
Chris Schneider Finance Committee	5071 Prairie Sage Rd Naperville, IL 60564 chidschneider@aol.com	Vice President Blackrock 5071 Prairie Sage Rd. Naperville, IL 60564 (847) 338-5120
Director		
Carmi Smith Advocacy Committee	6318 Winston Drive Woodridge, IL 60517 (630) 297-8638 Carmu77@aol.net	Editor/Writer
Director		
Robert F. Spahn, Jr, CLU, ChFc Golf Committee	933 Kent Elmhurst, IL 60126 rbsen.spahn@mhmn.com	Financial Advisor Northwestern Mutual 377 E. Butterfield Rd., Suite 325 Lombard, IL 60148 (630) 458-7019
Director		
Stephanie Stomberg Advocacy Committee Development Committee	1324 Reid Street Western Springs, IL 60558 (708) 784-9802 (h) ss@Cassidy.com	Partner Cassidy Schade LLP 20 N Wacker Drive, Suite 1000 Chicago, IL 60606 (312) 444-1660