

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 0042309

Facility Name: Forest Hill Health & Rehab Center, Inc

Address: 4747 11th Street East Moline 61244
Number City Zip Code

County: Rock Island

Telephone Number: 309-796-0922 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: 09/06/96

Type of Ownership:

VOLUNTARY, NON-PROFIT
Charitable Corp.
Trust
IRS Exemption Code

X PROPRIETARY
Individual
Partnership
Corporation
X "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: Mendel S Schneider Telephone Number: 847-933-1274
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 01/01/11 to 12/31/11 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) See Accountant's Report Attached
(Firm Name & Address) Mendel S Schneider & Associates, CPA, PC
4556 Oakton St, Ste 200, Skokie, IL 60076
(Telephone) 847-933-1274 Fax # 847-933-1283

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 Forest Hill Health & Rehab Center, Inc

0042309 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	<u>97</u>	Skilled (SNF)	<u>97</u>	<u>35,405</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>40</u>	Intermediate (ICF)	<u>40</u>	<u>14,600</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>137</u>	TOTALS	<u>137</u>	<u>50,005</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>2,746</u>	<u>281</u>	<u>632</u>	<u>3,659</u>	8
9	SNF/PED					9
10	ICF	<u>24,718</u>	<u>1,000</u>		<u>25,718</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>27,464</u>	<u>1,281</u>	<u>632</u>	<u>29,377</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.75%

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

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

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 ☒

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

I. On what date did you start providing long term care at this location?
Date started 09/06/96

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 09/06/96 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 56 and days of care provided 632

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

Facility Name & ID Number Forest Hill Health & Rehab Center, Inc # 0042309 Report Period Beginning: 01/01/11 Ending: 12/31/11
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	171,248	15,905	6,166	193,319		193,319		193,319			1
2	Food Purchase		248,069		248,069	(8,000)	240,069		240,069			2
3	Housekeeping	107,759	14,864		122,623		122,623		122,623			3
4	Laundry	36,720	3,546		40,266		40,266		40,266			4
5	Heat and Other Utilities			113,338	113,338		113,338		113,338			5
6	Maintenance	33,301	2,989	4,359	40,649		40,649	39,336	79,985			6
7	Other (specify):*											7
8	TOTAL General Services	349,028	285,373	123,863	758,264	(8,000)	750,264	39,336	789,600			8
	B. Health Care and Programs											
9	Medical Director			39,000	39,000		39,000		39,000			9
10	Nursing and Medical Records	1,141,354	74,359	8,022	1,223,735		1,223,735		1,223,735			10
10a	Therapy											10a
11	Activities	16,267	1,922		18,189		18,189		18,189			11
12	Social Services	53,173		3,604	56,777		56,777		56,777			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,210,794	76,281	50,626	1,337,701		1,337,701		1,337,701			16
	C. General Administration											
17	Administrative	52,552			52,552		52,552		52,552			17
18	Directors Fees											18
19	Professional Services			22,971	22,971		22,971		22,971			19
20	Dues, Fees, Subscriptions & Promotions			2,546	2,546		2,546	(556)	1,990			20
21	Clerical & General Office Expenses	71,354	35,472	8,147	114,973		114,973	28,716	143,689			21
22	Employee Benefits & Payroll Taxes			268,432	268,432	8,000	276,432		276,432			22
23	Inservice Training & Education											23
24	Travel and Seminar			860	860		860		860			24
25	Other Admin. Staff Transportation			11,385	11,385		11,385	2,921	14,306			25
26	Insurance-Prop.Liab.Malpractice			145,000	145,000		145,000	5,527	150,527			26
27	Other (specify):*											27
28	TOTAL General Administration	123,906	35,472	459,341	618,719	8,000	626,719	36,608	663,327			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,683,728	397,126	633,830	2,714,684		2,714,684	75,944	2,790,628			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			5,267	5,267		5,267	64,786	70,053			30
31	Amortization of Pre-Op. & Org.							8,801	8,801			31
32	Interest			27,897	27,897		27,897	140,051	167,948			32
33	Real Estate Taxes							73,704	73,704			33
34	Rent-Facility & Grounds			338,723	338,723		338,723	(335,133)	3,590			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* MIP Insurance							10,331	10,331			36
37	TOTAL Ownership			371,887	371,887		371,887	(37,460)	334,427			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			75,007	75,007		75,007		75,007			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			75,007	75,007		75,007		75,007			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,683,728	397,126	1,080,724	3,161,578		3,161,578	38,484	3,200,062			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	3,145	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				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(556)	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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 2,589		\$	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)	668		34
35	Other- Attach Schedule Allocated Indirect Costs	35,227		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 35,895		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 38,484		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

Report Period Beginning:

ID#0042309

Ending:

01/01/11

12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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
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	0	49

Summary A

12/31/11

[illegible]

Summary B

12/31/11

[illegible]

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
Michael Lerner	100	Galesburg Terrace	Galesburg	Gem Properties	East Moline	Bldg rental
				Gem Healthcare	Chicago	Management

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	34	Rent	\$ 338,723	Gem Healthcare Properties, LLC	100.00%	\$	(338,723)	1
2	V	32	Interest		Gem Healthcare Properties, LLC		140,051	140,051	2
3	V	30	Depreciation		Gem Healthcare Properties, LLC		61,641	61,641	3
4	V	31	Amortization		Gem Healthcare Properties, LLC		8,801	8,801	4
5	V	33	Real Estate Tax		Gem Healthcare Properties, LLC		73,704	73,704	5
6	V	26	Insurance		Gem Healthcare Properties, LLC		5,527	5,527	6
7	V	36	MIP Insurance		Gem Healthcare Properties, LLC		10,331	10,331	7
8	V	6	Repairs and Maintenance		Gem Healthcare Properties, LLC		39,336	39,336	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 338,723			\$ 339,391	\$ * 668	14

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

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

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									\$		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 Forest Hill Health & Rehab Center, Inc # 0042309 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Gem Healthcare Inc.
Street Address 3553 W Peterson
City / State / Zip Code Chicago, IL 60659
Phone Number (773-279-9420
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	34	Rent		245		\$ 6,420	\$	137	\$ 3,590	1
2	21	Office		245		51,354		137	28,716	2
3	25	Auto & Travel		245		5,223		137	2,921	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					\$ 62,997	\$		\$ 35,227	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	Midland		X	Mortgage	\$27,753.17	04/20/09	\$ 2,107,400	\$ 2,065,479	05/12/44	6.7500	\$ 140,051	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Albany Bank		X	Working Capital		01/01/08	504,000	700,000		7.0000	27,897	6	
7												7	
8												8	
9	TOTAL Facility Related				\$27,753.17		\$ 2,611,400	\$ 2,765,479			\$ 167,948	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 2,611,400	\$ 2,765,479			\$ 167,948	15	

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

* 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 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	74,855	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.)				\$	72,823	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(2,032)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	75,736	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.				\$	73,704	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2006	68,436	8	FOR BHF USE ONLY	
		2007	68,435	9		
		2008	70,399	10		
		2009	71,976	11		
		2010	72,823	12		
72823 x 1.04				13	FROM R. E. TAX STATEMENT FOR 2010 \$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Forest Hill Health & Rehab Center, Inc COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0042309

CONTACT PERSON REGARDING THIS REPORT Michael Lerner

TELEPHONE 773-279-9420 FAX #: ()

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>07-060-03-60</u>	<u></u>	\$ <u>72,823.00</u>	\$ <u>72,823.00</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u><u>72,823.00</u></u>	\$ <u><u>72,823.00</u></u>

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

B. General Construction Type:

Exterior

Frame

Number of Stories

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:

132,026

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

12/01, 04/09

3. Current Period Amortization:

8,801

4. Dates Incurred:

12/01, 04/09

Nature of Costs: Closing 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	Facility		1996	\$ 64,114	1
2					2
3	TOTALS			\$ 64,114	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	137		1996		\$ 2,438,383	\$ 61,128	39	\$ 62,523	\$ 1,395	\$ 937,845	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Awning			1996	628	16	39	16		240	9	
10	Carpeting			2000	29,278	751	39	751		8,980	10	
11	Floor Tiling			2002	9,714	249	39	249		2,272	11	
12	Asphalt Covering			2004	6,725	397	15	518	121	4,140	12	
13	Therapy Room			2005	29,858	1,861	15	2,553	692	17,095	13	
14	Roof			2006	19,725	1,036	15	1,874	838	10,356	14	
15	Fire Alarm			2006	5,080	352	15	483	131	2,669	15	
16	Concrete			2006	8,750	606	15	831	225	4,593	16	
17	Compressor			2009	5,684	146	39	72	(74)	216	17	
18	Aphalt			2009	14,287	366	39	183	(183)	549	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

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	
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									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$2,568,112	\$66,908		\$70,053	\$3,145	\$988,955	70

**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	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	480,941					480,941	73
74								74
75	TOTALS	\$ 480,941	\$	\$	\$		\$ 480,941	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 3,113,167	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 66,908	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 70,053	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,145	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,469,896	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:
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	Allocated from Gem Healthcare				3,590			5
6								6
7	TOTAL				\$3,590			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: \$
- Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		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)	\$			

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.

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

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

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	\$ 100	\$ 100	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	820,878	820,878	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	117,099	117,099	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Others, Escrow	580,128	960,011	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,518,205	\$ 1,898,088	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		64,114	13
14	Buildings, at Historical Cost		2,438,383	14
15	Leasehold Improvements, at Historical Cost	109,758	129,729	15
16	Equipment, at Historical Cost	42,438	480,941	16
17	Accumulated Depreciation (book methods)	(87,285)	(1,698,377)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		166,219	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(63,374)	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)	\$ 64,911	\$ 1,517,635	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,583,116	\$ 3,415,723	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 196,981	\$ 196,981	26
27	Officer's Accounts Payable	335,000	335,000	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	700,000	700,000	29
30	Accrued Salaries Payable	52,643	54,643	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,734	3,734	31
32	Accrued Real Estate Taxes(Sch.IX-B)		75,736	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to LLC	883,930		36
37	Due to Others	25,000	25,000	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,197,288	\$ 1,391,094	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		2,065,479	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 2,065,479	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,197,288	\$ 3,456,573	46
47	TOTAL EQUITY(page 18, line 24)	\$ (614,172)	\$ (40,850)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,583,116	\$ 3,415,723	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (653,562)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (653,562)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	39,390	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)	\$ 39,390	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)	\$ (614,172)	24 *

* This must agree with page 17, line 47.

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			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,200,968	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,200,968	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		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		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)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,200,968	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	758,264	31
32	Health Care	1,337,701	32
33	General Administration	618,719	33
	B. Capital Expense		
34	Ownership	371,887	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	75,007	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,161,578	40
41	Income before Income Taxes (line 30 minus line 40)**	39,390	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 39,390	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No, Cash Basis 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	2,080	2,232	\$ 50,769	\$ 22.75	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,371	5,716	106,112	18.56	3
4	Licensed Practical Nurses	21,179	22,335	369,813	16.56	4
5	CNAs & Orderlies	52,013	54,818	559,167	10.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,810	1,950	16,267	8.34	10
11	Social Service Workers	4,408	4,489	53,173	11.85	11
12	Dietician					12
13	Food Service Supervisor	4,572	4,711	55,665	11.82	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,728	13,461	115,583	8.59	15
16	Dishwashers					16
17	Maintenance Workers	2,240	2,286	33,301	14.57	17
18	Housekeepers	11,031	12,065	107,759	8.93	18
19	Laundry	5,657	6,192	36,720	5.93	19
20	Administrator	1,440	1,600	52,552	32.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,122	5,895	71,354	12.10	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	2,080	2,196	55,493	25.27	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	129,731	139,946	\$ 1,683,728 *	\$ 12.03	34

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	94	\$ 6,166	1-3	35
36	Medical Director	275	39,000	9-3	36
37	Medical Records Consultant	60	3,056	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	120	4,966	10-3	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	72	3,604	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	621	\$ 56,792		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberForest Hill Health & Rehab Center, Inc# 0042309Report Period Beginning:01/01/11Ending:12/31/11Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karen Leighty	Administrator		\$ 39,380
Judy Scott	Administrator		13,172
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 52,552

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Mendel S Schneider	Accounting	\$ 12,000
Galetsis & Associates	Accounting	2,818
Mcvey & Parsky, LLC	Legal	4,812
Professional Planners	UC Consultant	841
Eli Olebaum	Accounting	2,500
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 22,971

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 63,067	
Unemployment Compensation Insurance	26,737	
FICA Taxes	128,805	
Employee Health Insurance	49,823	
Employee Meals	8,000	
Illinois Municipal Retirement Fund (IMRF)*		
TOTAL (agree to Schedule V, line 22, col.8)		\$ 276,432

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	\$ 1,990	
Advertising: Employee Recruitment		
Health Care Worker Background Check (Indicate # of checks performed)		
Patient Background Checks		
Advertising	556	
Less: Public Relations Expense	()	
Non-allowable advertising	(556)	
Yellow page advertising	()	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 1,990

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	
ICLTC	860
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 860

* 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
N/A

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 9,500 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 X
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11)

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

\$ 75,007

(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?

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?
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 benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 8,000
No

Indicate the amount. \$ 0

(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.

No 0

c.

What percent of all travel expense relates to transportation of nurses and patients?

0

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?

No

f.

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

No

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

\$ 0

(17)

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

No

N/A

(18)

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

Yes

(19)

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

N/a