

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

Address: 4747 - 11th St 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

☒ 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: 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 01/01/12 to 12/31/12 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) _____
(Title) _____

Paid
Preparer

(Signed) _____
(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# 0042309 Report Period Beginning: 01/01/12 Ending: 12/31/12

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>35,502</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>40</u>	Intermediate (ICF)	<u>40</u>	<u>14,640</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	137	TOTALS	137	50,142	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>2,717</u>	<u>536</u>	<u>765</u>	<u>4,018</u>	8
9	SNF/PED					9
10	ICF	<u>24,451</u>			<u>24,451</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,168	536	765	28,469	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 56.78%

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?

YesG. 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 09/06/96NO ☐

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 765Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ 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.

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	164,682	41,504	5,248	211,434		211,434		211,434			1
2	Food Purchase		260,416		260,416	(8,000)	252,416		252,416			2
3	Housekeeping	130,437	10,205		140,642		140,642		140,642			3
4	Laundry	36,141	5,235		41,376		41,376		41,376			4
5	Heat and Other Utilities			117,743	117,743		117,743		117,743			5
6	Maintenance	39,876	7,147	12,891	59,914		59,914	40,392	100,306			6
7	Other (specify):*											7
8	TOTAL General Services	371,136	324,507	135,882	831,525	(8,000)	823,525	40,392	863,917			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	1,088,415	59,498	6,878	1,154,791		1,154,791		1,154,791			10
10a	Therapy											10a
11	Activities	12,000	3,833		15,833		15,833		15,833			11
12	Social Services	52,642		2,511	55,153		55,153		55,153			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,153,057	63,331	39,389	1,255,777		1,255,777		1,255,777			16
	C. General Administration											
17	Administrative	43,044			43,044		43,044		43,044			17
18	Directors Fees											18
19	Professional Services			24,005	24,005		24,005		24,005			19
20	Dues, Fees, Subscriptions & Promotions			6,884	6,884		6,884	(1,404)	5,480			20
21	Clerical & General Office Expenses	64,011	62,123	12,356	138,490		138,490	42,448	180,938			21
22	Employee Benefits & Payroll Taxes			245,573	245,573	8,000	253,573		253,573			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,910	1,910		1,910		1,910			24
25	Other Admin. Staff Transportation			13,730	13,730		13,730	3,350	17,080			25
26	Insurance-Prop.Liab.Malpractice			145,000	145,000		145,000	6,600	151,600			26
27	Other (specify):*											27
28	TOTAL General Administration	107,055	62,123	449,458	618,636	8,000	626,636	50,994	677,630			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,631,248	449,961	624,729	2,705,938		2,705,938	91,386	2,797,324			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			5,158	5,158		5,158	64,895	70,053			30
31	Amortization of Pre-Op. & Org.							8,801	8,801			31
32	Interest			32,123	32,123		32,123	127,337	159,460			32
33	Real Estate Taxes							72,515	72,515			33
34	Rent-Facility & Grounds			311,253	311,253		311,253	(307,663)	3,590			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*							10,240	10,240			36
37	TOTAL Ownership			348,534	348,534		348,534	(23,875)	324,659			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			243,376	243,376		243,376		243,376			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			243,376	243,376		243,376		243,376			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,631,248	449,961	1,216,639	3,297,848		3,297,848	67,511	3,365,359			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	3,255	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	(1,404)	20		25
	Income Taxes and Illinois Personal				
26	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)	\$ 1,851		\$	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	2	
		Amount	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)	16,272		34
35	Other- Attach Schedule Allocated Indirect Costs:	49,388		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 65,660		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 67,511		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	2	3	4	
		Yes	No	Amount	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

Forest Hill Health & Rehab

Report Period Beginning:

Ending:

ID#004230901/01/1212/31/12

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Forest Hill Health & Rehab # 0042309 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	40,392	0	0	0	0	0	0	0	0	0	40,392	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	40,392	0	0	0	0	0	0	0	0	0	40,392	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	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,404)	0	0	0	0	0	0	0	0	0	0	(1,404)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	6,600	0	0	0	0	0	0	0	0	0	6,600	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(1,404)	6,600	0	0	0	0	0	0	0	0	0	5,196	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,404)	46,992	0	0	0	0	0	0	0	0	0	45,588	29

STATE OF ILLINOIS

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	3,255	61,640	0	0	0	0	0	0	0	0	0	64,895	30
31	Amortization of Pre-Op. & Org.	0	8,801	0	0	0	0	0	0	0	0	0	8,801	31
32	Interest	0	127,337	0	0	0	0	0	0	0	0	0	127,337	32
33	Real Estate Taxes	0	72,515	0	0	0	0	0	0	0	0	0	72,515	33
34	Rent-Facility & Grounds	0	(311,253)	0	0	0	0	0	0	0	0	0	(311,253)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	10,240	0	0	0	0	0	0	0	0	0	10,240	36
37	TOTAL Ownership	3,255	(30,720)	0	0	0	0	0	0	0	0	0	(27,465)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	1,851	16,272	0	0	0	0	0	0	0	0	0	18,123	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
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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 311,253	Gem Healthcare Properties, LLC	100.00%	\$	(311,253)	1
2	V	32	Interest		Gem Healthcare Properties, LLC		127,337	127,337	2
3	V	30	Depreciation		Gem Healthcare Properties, LLC		61,640	61,640	3
4	V	31	Amortization		Gem Healthcare Properties, LLC		8,801	8,801	4
5	V	33	Real Estate Tax		Gem Healthcare Properties, LLC		72,515	72,515	5
6	V	26	Insurance		Gem Healthcare Properties, LLC		6,600	6,600	6
7	V	36	MIP Insurance		Gem Healthcare Properties, LLC		10,240	10,240	7
8	V	6	Repairs and Maintenance		Gem Healthcare Properties, LLC		40,392	40,392	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 311,253			\$ 327,525	\$ * 16,272	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 # 0042309 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	34	Rent		245		\$ 6,420	\$	137	\$ 3,590	1
2	21	Office		245		75,911		137	42,448	2
3	25	Auto & Travel		245		5,990		137	3,350	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					\$ 88,321	\$		\$ 49,388	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	\$ 2,048,763	05/12/44	6.7500	\$ 127,337	1							
2												2							
3												3							
4												4							
5												5							
	Working Capital																		
6	Albany Bank		X	Working Capital		01/01/08	504,000	700,000		5.0000	32,123	6							
7												7							
8												8							
9	TOTAL Facility Related				\$27,753.17		\$ 2,611,400	\$ 2,748,763			\$ 159,460	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	\$ 2,748,763			\$ 159,460	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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.		\$	75,736	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.)		\$	72,672	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(3,064)	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	75,579	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.		\$	72,515	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	68,435	8	
		2008	70,399	9	
		2009	71,976	10	
		2010	72,823	11	
		2011	72,672	12	
72672 X 1.04					

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$		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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Forest Hill Health & Rehab 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 2011 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 2011.

(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>72,672.00</u>	\$ <u>72,672.00</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>72,672.00</u></u>	\$ <u><u>72,672.00</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 X 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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?

X

(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?

X

(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?

X

YES

NO

If so, please complete the following:

1. Total Amount Incurred:

132,026

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

15

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	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		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	\$ 1,000,368	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Awning		1996		628	16	39	16		256	9
10	Carpeting		2000		29,278	751	39	751		9,731	10
11	Floor Tiling		2002		9,714	249	39	249		2,521	11
12	Asphalt Covering		2004		6,725	397	15	518	121	4,658	12
13	Therapy Room		2005		29,858	1,763	15	2,553	790	19,648	13
14	Roof		2006		19,725	1,165	15	1,874	709	12,230	14
15	Fire Alarm		2006		5,080	300	15	483	183	3,152	15
16	Concrete		2006		8,750	517	15	831	314	5,424	16
17	Compressor		2009		5,684	146	39	72	(74)	288	17
18	Asphalt		2009		14,287	366	39	183	(183)	732	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	\$66,798		\$70,053	\$3,255	\$1,059,008	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 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)	\$ 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)	\$ 66,798	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)	\$ 3,255	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,539,949	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

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. /2013\$
13. /2014\$
14. /2015\$

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

* 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

ALLOCATION OF COSTS (d)

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

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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	2	
		Operating	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)	750,196	750,196	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	101,783	101,783	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Others, Escrow	215,128	630,151	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,067,207	\$ 1,482,230	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)	(92,443)	(1,765,175)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		166,219	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(72,175)	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)	\$ 59,753	\$ 1,442,036	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,126,960	\$ 2,924,266	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 366,761	\$ 366,761	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	700,000	700,000	29
30	Accrued Salaries Payable	45,125	45,125	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,214	5,214	31
32	Accrued Real Estate Taxes(Sch.IX-B)		75,579	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)	\$ 2,026,030	\$ 1,217,679	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		2,048,763	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)	\$	\$ 2,048,763	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,026,030	\$ 3,266,442	46
47	TOTAL EQUITY(page 18, line 24)	\$ (899,070)	\$ (342,176)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,126,960	\$ 2,924,266	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (614,172)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (614,172)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(284,898)	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)	\$ (284,898)	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)	\$ (899,070)	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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,012,950	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,012,950	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)	\$ 3,012,950	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	831,525	31
32	Health Care	1,255,777	32
33	General Administration	618,636	33
	B. Capital Expense		
34	Ownership	348,534	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	243,376	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,297,848	40
41	Income before Income Taxes (line 30 minus line 40)**	(284,898)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (284,898)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,732,829	44
45	Private Pay - Net Inpatient Revenue	76,648	45
46	Medicare - Net Inpatient Revenue	203,473	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,012,950	49

* 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	\$ 52,500	\$ 23.52	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,481	7,959	151,223	19.00	3
4	Licensed Practical Nurses	20,105	21,163	358,720	16.95	4
5	CNAs & Orderlies	42,432	44,665	460,945	10.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,329	1,429	12,000	8.40	10
11	Social Service Workers	4,309	4,442	52,642	11.85	11
12	Dietician					12
13	Food Service Supervisor	4,557	4,698	56,000	11.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,573	12,579	108,682	8.64	15
16	Dishwashers					16
17	Maintenance Workers	2,578	2,685	39,876	14.85	17
18	Housekeepers	13,593	14,461	130,437	9.02	18
19	Laundry	4,011	4,178	36,141	8.65	19
20	Administrator	2,000	2,080	43,044	20.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,047	5,204	64,011	12.30	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	2,000	2,080	65,027	31.26	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	123,095	129,855	\$ 1,631,248 *	\$ 12.56	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	82	\$ 5,248	1-3	35
36	Medical Director	215	30,000	9-3	36
37	Medical Records Consultant	6	303	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	160	6,575	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	50	2,511	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	513	\$ 44,637		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.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
Judy Scott	Administrator		\$ 43,044	Workers' Compensation Insurance		\$ 44,399	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance		25,717	Advertising: Employee Recruitment		
				FICA Taxes		124,790	Health Care Worker Background Check		
				Employee Health Insurance		50,667	(Indicate # of checks performed 50)	500	
				Employee Meals		8,000	Patient Background Checks	50	
				Illinois Municipal Retirement Fund (IMRF)*			Advertising	1,404	
							Misc Licenses	2,490	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 43,044				Less: Public Relations Expense	()	
B. Administrative - Other							Non-allowable advertising	(1,404)	
Description			Amount				Yellow page advertising	()	
			\$						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				TOTAL (agree to Sch. V, line 20, col. 8)	\$ 5,480	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Mendel S Schneider	Accounting		\$ 12,000			\$	Out-of-State Travel	\$	
Eli Olebaum	Accounting		4,000						
Galetsis & Associates	Accounting		2,190						
Mcvey & Parsky, LLC	Legal		4,895				In-State Travel		
Professional Planners	UC Consultant		920						
							Seminar Expense		
							ICLTC	1,910	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 24,005	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,910	

*** Attach copy of IMRF notifications**

****See instructions.**

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

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

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? No
If YES, give association name and amount. _____

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 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? Yes If NO, attach a complete explanation.

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

(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. \$ 243,376
This amount is to be recorded on line 42 of Schedule V.

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

(13)

(14)

(15)

(16)

(17)

(18)

(19)

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

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

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 8,000 Has any meal income been offset against related costs? No Indicate the amount. \$ 0

Travel and Transportation

a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients? 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? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0

Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____

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

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