

Facility Name & ID Number Forest Hill Health and Rehab

0042309 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	2,570	130	855	3,555	8
9	SNF/PED					9
10	ICF	23,128	1,218		24,346	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,698	1,348	855	27,901	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.80%

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 855

Medicare 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.

Facility Name & ID Number Forest Hill Health and Rehab # 0042309 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	164,709	12,500	8,015	185,224		185,224		185,224		1
2	Food Purchase		187,891		187,891	(8,000)	179,891		179,891		2
3	Housekeeping	101,068	2,804	7,530	111,402		111,402		111,402		3
4	Laundry	33,313	8,755		42,068		42,068		42,068		4
5	Heat and Other Utilities			123,029	123,029		123,029		123,029		5
6	Maintenance	48,985		4,208	53,193		53,193	23,013	76,206		6
7	Other (specify):*										7
8	TOTAL General Services	348,075	211,950	142,782	702,807	(8,000)	694,807	23,013	717,820		8
	B. Health Care and Programs										
9	Medical Director			40,000	40,000		40,000		40,000		9
10	Nursing and Medical Records	1,045,612	49,732	2,772	1,098,116		1,098,116		1,098,116		10
10a	Therapy										10a
11	Activities	23,416	5,318		28,734		28,734		28,734		11
12	Social Services	41,842		3,427	45,269		45,269		45,269		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,110,870	55,050	46,199	1,212,119		1,212,119		1,212,119		16
	C. General Administration										
17	Administrative	71,074			71,074		71,074		71,074		17
18	Directors Fees										18
19	Professional Services			19,785	19,785		19,785		19,785		19
20	Dues, Fees, Subscriptions & Promotions			3,442	3,442		3,442	(1,366)	2,076		20
21	Clerical & General Office Expenses	77,339	19,555	12,655	109,549		109,549	36,675	146,224		21
22	Employee Benefits & Payroll Taxes			257,000	257,000	8,000	265,000		265,000		22
23	Inservice Training & Education										23
24	Travel and Seminar			250	250		250	3,307	3,557		24
25	Other Admin. Staff Transportation			10,454	10,454		10,454		10,454		25
26	Insurance-Prop.Liab.Malpractice			145,625	145,625		145,625	7,079	152,704		26
27	Other (specify):*										27
28	TOTAL General Administration	148,413	19,555	449,211	617,179	8,000	625,179	45,695	670,874		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,607,358	286,555	638,192	2,532,105		2,532,105	68,708	2,600,813		29

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

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

Facility Name & ID Number Forest Hill Health and Rehab

#0042309

Report Period Beginning:

01/01/10

Ending:

12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			5,598	5,598		5,598	64,455	70,053			30
31	Amortization of Pre-Op. & Org.							8,801	8,801			31
32	Interest			22,510	22,510		22,510	140,995	163,505			32
33	Real Estate Taxes							72,912	72,912			33
34	Rent-Facility & Grounds			341,538	341,538		341,538	(337,948)	3,590			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* MIP Insurance							10,416	10,416			36
37	TOTAL Ownership			369,646	369,646		369,646	(40,369)	329,277			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			75,008	75,008		75,008		75,008			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			75,008	75,008		75,008		75,008			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,607,358	286,555	1,082,846	2,976,759		2,976,759	28,339	3,005,098			45

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

Facility Name & ID Number **Forest Hill Health and Rehab**

0042309

Report Period Beginning:

01/01/10

Ending:

12/31/10

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.)

		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	2,815	30		9
10	Interest and Other Investment Income	(79)	32		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	(1,366)	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)	\$ 1,370		\$	30

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)	(16,603)		34
35	Other- Attach Schedule Allocated Indirect Costs	43,572		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 26,969		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 28,339		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

BHF USE ONLY

48		49		50		51		52	
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Forest Hill Health and Rehab

ID# 0042309

Report Period Beginning: 01/01/10

Ending: 12/31/10

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 and Rehab# 0042309

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	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	23,013	0	0	0	0	0	0	0	0	0	23,013	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	23,013	0	0	0	0	0	0	0	0	0	23,013	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	(1,366)	0	0	0	0	0	0	0	0	0	0	(1,366)	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	7,079	0	0	0	0	0	0	0	0	0	7,079	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(1,366)	7,079	0	0	0	0	0	0	0	0	0	5,713	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,366)	30,092	0	0	0	0	0	0	0	0	0	28,726	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Forest Hill Health and Rehab# 0042309

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	2,815	61,640	0	0	0	0	0	0	0	0	0	64,455	30
31	Amortization of Pre-Op. & Org.	0	8,801	0	0	0	0	0	0	0	0	0	8,801	31
32	Interest	(79)	141,074	0	0	0	0	0	0	0	0	0	140,995	32
33	Real Estate Taxes	0	72,912	0	0	0	0	0	0	0	0	0	72,912	33
34	Rent-Facility & Grounds	0	(341,538)	0	0	0	0	0	0	0	0	0	(341,538)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	10,416	0	0	0	0	0	0	0	0	0	10,416	36
37	TOTAL Ownership	2,736	(46,695)	0	(43,959)	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)	1,370	(16,603)	0	0	0	0	0	0	0	0	0	(15,233)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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	\$ 341,538	Gem Healthcare Properties, LLC	100.00%	\$	\$ (341,538)	1
2	V	32 Interest		Gem Healthcare Properties, LLC		141,074	141,074	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		72,912	72,912	5
6	V	26 Insurance		Gem Healthcare Properties, LLC		7,079	7,079	6
7	V	36 MIP Insurance		Gem Healthcare Properties, LLC		10,416	10,416	7
8	V	6 Repairs and Maintenance		Gem Healthcare Properties, LLC		23,013	23,013	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 341,538			\$ 324,935	\$ * (16,603)	14

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

Facility Name & ID Number Forest Hill Health and Rehab # 0042309 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 and Rehab

0042309

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

()

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.

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		65,587		137	36,675	2
3	25	Auto & Travel	245		5,914		137	3,307	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				\$ 77,921	\$		\$ 43,572	25

Facility Name & ID Number

Forest Hill Health and Rehab

0042309

Report Period Beginning:

01/01/10

Ending:

12/31/10

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										
										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	\$ 2,082,576	05/12/44	6.7500	\$ 141,074	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6	Albany Bank		X	Working Capital		01/01/08	504,000	600,000		7.0000	22,510	6							
7												7							
8												8							
9	TOTAL Facility Related				\$27,753.17		\$ 2,611,400	\$ 2,682,576			\$ 163,584	9							
B. Non-Facility Related*																			
10	Interest Income										(79)	10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (79)	14							
15	TOTALS (line 9+line14)						\$ 2,611,400	\$ 2,682,576			\$ 163,505	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 10,416 Line # 36

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

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

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 2009 report.	\$	73,919	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.)	\$	71,976	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(1,943)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	74,855	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.	\$	72,912	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2005	79,169	8
	2006	68,436	9
	2007	68,435	10
	2008	70,399	11
	2009	71,976	12

Line 4: 71976 x 1.04

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2009	\$	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.

Facility Name & ID Number Forest Hill Health and Rehab

0042309

Report Period Beginning:

01/01/10

Ending:

12/31/10

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1			1996	\$ 64,114	1
2					2
3	TOTALS			\$ 64,114	3

Facility Name & ID Number Forest Hill Health and Rehab

0042309

Report Period Beginning:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	\$ 875,322	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Awning	1996		628	16	39	16		224	9
10	Carpeting	2000		29,278	751	39	751		8,229	10
11	Floor Tiling	2002		9,714	249	39	249		2,023	11
12	Asphalt Covering	2004		6,725	397	15	518	121	3,622	12
13	Therapy Room	2005		29,858	1,861	15	2,553	692	14,542	13
14	Roof	2006		19,725	1,366	15	1,874	508	8,482	14
15	Fire Alarm	2006		5,080	352	15	483	131	2,186	15
16	Concrete	2006		8,750	606	15	831	225	3,762	16
17	Compressor	2009		5,684	146	39	72	(74)	144	17
18	Asphalt	2009		14,287	366	39	183	(183)	366	18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Forest Hill Health and Rehab

0042309

Report Period Beginning:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	\$ 67,238		\$ 70,053	\$ 2,815	\$ 918,902	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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 Depreciation (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)	\$ 67,238	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)	\$ 2,815	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,399,843	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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

* 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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	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 prescripts							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.

Facility Name & ID Number **Forest Hill Health and Rehab**

0042309

Report Period Beginning: **01/01/10**

Ending: **12/31/10**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/10** (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 100	\$ 100	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	731,212	731,212	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	107,903	110,790	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Others, Escrow	580,128	914,669	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,419,343	\$ 1,756,771	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)	(82,018)	(1,631,469)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		166,219	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(54,573)	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)	\$ 70,178	\$ 1,593,344	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,489,521	\$ 3,350,115	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 253,703	\$ 253,703	26
27	Officer's Accounts Payable	335,000	335,000	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	600,000	600,000	29
30	Accrued Salaries Payable	40,878	40,878	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,572	4,572	31
32	Accrued Real Estate Taxes(Sch.IX-B)		74,855	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)	\$ 2,143,083	\$ 1,334,008	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,082,576	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)	\$	\$ 2,082,576	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,143,083	\$ 3,416,584	46
47	TOTAL EQUITY(page 18, line 24)	\$ (653,562)	\$ (66,469)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,489,521	\$ 3,350,115	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (794,066)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (794,066)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	140,504	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)	\$ 140,504	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)	\$ (653,562)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Forest Hill Health and Rehab# 0042309Report Period Beginning: 01/01/10Ending: 12/31/10

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	\$ 3,117,184	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,117,184	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***	79	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 79	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)	\$ 3,117,263	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	702,807	31
32	Health Care	1,212,119	32
33	General Administration	617,179	33
B. Capital Expense			
34	Ownership	369,646	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	75,008	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,976,759	40
41	Income before Income Taxes (line 30 minus line 40)**	140,504	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 140,504	43

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

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

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

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

Facility Name & ID Number **Forest Hill Health and Rehab**

0042309

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	2,008	2,232	\$ 50,000	\$ 22.40	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,460	2,588	74,384	28.74	3
4	Licensed Practical Nurses	21,448	22,208	364,938	16.43	4
5	CNAs & Orderlies	38,050	40,672	489,971	12.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,627	2,891	23,416	8.10	10
11	Social Service Workers	3,435	3,627	41,842	11.54	11
12	Dietician					12
13	Food Service Supervisor	4,965	5,128	51,743	10.09	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,057	11,697	112,966	9.66	15
16	Dishwashers					16
17	Maintenance Workers	3,653	3,842	48,985	12.75	17
18	Housekeepers	10,928	11,568	101,068	8.74	18
19	Laundry	3,646	3,766	33,313	8.85	19
20	Administrator	2,080	2,196	71,074	32.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,200	6,464	77,339	11.96	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	3,589	3,789	66,319	17.50	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	116,146	122,668	\$ 1,607,358 *	\$ 13.10	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	120	\$ 8,015	1-3	35
36	Medical Director	280	40,000	9-3	36
37	Medical Records Consultant	5	250	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	60	2,522	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	70	3,427	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	535	\$ 54,214		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

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	
Karen Leighty	Administrator		\$ 71,074	Workers' Compensation Insurance	\$ 70,065	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	14,862	Advertising: Employee Recruitment		
				FICA Taxes	122,963	Health Care Worker Background Check		
				Employee Health Insurance	49,110	(Indicate # of checks performed _____)		
				Employee Meals	8,000	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Advertising	1,366	
						Misc Dues	86	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 71,074					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount		\$ 265,000	Less: Public Relations Expense	()	
			\$			Non-allowable advertising	(1,366)	
						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)		
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	\$
Galetsis & Associates	Accounting		2,517					
Professional Planners	UC Consultant		639				In-State Travel	
Mcvey & Parsky, LLC	Legal		4,629					
							Seminar Expense	
							ICLTC	250
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 19,785	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
								\$ 250

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Forest Hill Health and Rehab

0042309

Report Period Beginning:

01/01/10

Ending:

12/31/10

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. \$ 75,007
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 8,000 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 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? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted 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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.