

Facility Name & ID Number FOREST EDGE HC REHAB CTR

0052035 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	218	Skilled (SNF)	218	79,570	1
2		Skilled Pediatric (SNF/PED)			2
3	110	Intermediate (ICF)	110	40,150	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	328	TOTALS	328	119,720	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	33,045	31	12,232	45,308	8
9	SNF/PED					9
10	ICF	53,756	386	41	54,183	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	86,801	417	12,273	99,491	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.10%

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 11/01/12

J. Was the facility purchased or leased after January 1, 1978?

YES Date 11/01/12 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided 12,232

Medicare Intermediary NATIONAL GOVERNMENT SERVICE

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

* 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	363,124	49,480	16,481	429,085		429,085	16,240	445,325		1
2	Food Purchase		535,790		535,790	(33,726)	502,064	(928)	501,136		2
3	Housekeeping	427,237	91,875		519,112		519,112		519,112		3
4	Laundry	167,338	34,893	12,281	214,512		214,512		214,512		4
5	Heat and Other Utilities			300,146	300,146		300,146	931	301,077		5
6	Maintenance	107,794	41,193	110,092	259,079		259,079	2,149	261,228		6
7	Other (specify):* SECURITY	239,600		36,079	275,679		275,679	642	276,321		7
8	TOTAL General Services	1,305,093	753,231	475,079	2,533,403	(33,726)	2,499,677	19,034	2,518,711		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	3,828,398	151,212	40,116	4,019,726		4,019,726	60,378	4,080,104		10
10a	Therapy	131,328		6,210	137,538		137,538		137,538		10a
11	Activities	214,376	40,616		254,992		254,992		254,992		11
12	Social Services			5,657	5,657		5,657		5,657		12
13	CNA Training										13
14	Program Transportation			9,012	9,012		9,012		9,012		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,174,102	191,828	72,995	4,438,925		4,438,925	60,378	4,499,303		16
	C. General Administration										
17	Administrative			804,000	804,000	129,581	933,581	(778,907)	154,674		17
18	Directors Fees										18
19	Professional Services			206,923	206,923	(129,581)	77,342	140,281	217,623		19
20	Dues, Fees, Subscriptions & Promotions			50,902	50,902		50,902	(8,354)	42,548		20
21	Clerical & General Office Expenses	348,795	28,974	78,989	456,758		456,758	(49,576)	407,182		21
22	Employee Benefits & Payroll Taxes			1,016,203	1,016,203	33,726	1,049,929		1,049,929		22
23	Inservice Training & Education							1,069	1,069		23
24	Travel and Seminar			3,414	3,414		3,414		3,414		24
25	Other Admin. Staff Transportation			28,757	28,757		28,757	(2,141)	26,616		25
26	Insurance-Prop.Liab.Malpractice			286,320	286,320		286,320	38,544	324,864		26
27	Other (specify):*			293,449	293,449		293,449	(262,899)	30,550		27
28	TOTAL General Administration	348,795	28,974	2,768,957	3,146,726	33,726	3,180,452	(921,983)	2,258,469		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,827,990	974,033	3,317,031	10,119,054		10,119,054	(842,571)	9,276,483		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 PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	16,481
	REPAIRS & MAINTENANCE	0
		0
		16,481
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	12,281
		0
		12,281
5	HEAT & OTHER UTILITIES	
	GAS HEAT	95,306
	ELECTRICITY	124,382
	WATER	76,953
	CABLE TV - LOBBY	3,505
		0
		300,146
6	MAINTENANCE	
	GROUNDS MAINTENANCE	4,738
	PAINTING & DECORATING	672
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	35,309
	ELEVATOR MAINTENANCE & REPAIR	38,025
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	8,230
	FIRE SERVICE	23,118
		0
		0
		0
		0
		110,092
7	OTHER	
	SCAVENGER	34,436
	SECURITY SERVICE	1,643
		0
		0
		36,079
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	12,000
		12,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	17,512
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	15,744
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	0
	DENTAL	6,860
		0
		40,116
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	6,210
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		6,210
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	5,657
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		5,657
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	9,012
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	804,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	22,737
	ADMINISTRATIVE CONSULTANTS XIX C	129,581
	PROFESSIONAL FEES XIX C	54,605
		0
		206,923
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	11,090
	EMPLOYEE WANT ADS XIX F	0
	CONTRIBUTIONS VI 20 XIX F	250
	DUES & SUBSCRIPTIONS XIX F	24,651
	LICENSES & PERMITS XIX F	4,185
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	9,011
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,715
	PATIENT BACKGROUND CHECKS XIX F	0
		50,902
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	6,874
	EQUIPMENT REPAIR & MAINTENANCE	6,610
	OUTSIDE CLERICAL SERVICES	42,000
	PENALTIES / OVERDRAFT CHARGES VI 18	1,795
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	21,710
	MESSENGER SERVICE	0
		0
		78,989

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	431,469
	UNEMPLOYMENT COMPENSATION XIX D	78,577
	WORKERS COMPENSATION INSURANC XIX D	212,274
	HOSPITALIZATION INSURANCE XIX D	273,816
	EMPLOYEE BENEFITS - OTHER XIX D	16,019
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	4,048
		0
		1,016,203
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	3,414
	TRAVEL XIX G	0
		3,414
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	28,757
		28,757
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	286,320
		286,320
27	OTHER	
	BAD DEBTS VI 24	293,449
		293,449

GRAND TOTAL COLUMN 3 OTHER

3,317,031

**FOREST EDGE HC REHAB CTR
SCHEDULES
12/31/2013**

**EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	535,790
LESS SALES TAX	<u>(928)</u>
NET FOOD	534,862

TOTAL PATIENT CENSUS	99,491
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	298,473

ADD # EMPLOYEE MEALS/DAY	55
TIMES # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	20,075

PATIENT MEALS	298,473
ADD EMPLOYEE MEALS	<u>20,075</u>
TOTAL MEALS/YEAR	318,548

NET FOOD	534,862
DIVIDE TOTAL MEALS/YEAR	<u>318,548</u>

COST PER MEAL	1.68
TIMES EMPLOYEE MEALS	<u>20,075</u>
EMPLOYEE MEAL RECLASSIFICATION	<u>33,726</u>

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			20,778	20,778		20,778	757,452	778,230			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			111,003	111,003		111,003	706,415	817,418			32
33	Real Estate Taxes							343,278	343,278			33
34	Rent-Facility & Grounds			2,394,359	2,394,359		2,394,359	(2,381,806)	12,553			34
35	Rent-Equipment & Vehicles			57,168	57,168		57,168	7,045	64,213			35
36	Other (specify):* OFFICE RENT			26,364	26,364		26,364	55,577	81,941			36
37	TOTAL Ownership			2,609,672	2,609,672		2,609,672	(512,039)	2,097,633			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		174,039	971,373	1,145,412		1,145,412		1,145,412			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			735,938	735,938		735,938		735,938			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		174,039	1,707,311	1,881,350		1,881,350		1,881,350			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,827,990	1,148,072	7,634,014	14,610,076		14,610,076	(1,354,610)	13,255,466			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 EDGE HC REHAB CTR**

0052035

Report Period Beginning: **01/01/2013**

Ending: **12/31/2013**

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	(18,171)	30		9
10	Interest and Other Investment Income	(2,345)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(928)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(1,795)	21		18
19	Entertainment		20		19
20	Contributions	(9,261)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(293,449)	27		24
25	Fund Raising, Advertising and Promotional	(11,090)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(103,981)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (441,020)		\$	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)	(913,590)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (913,590)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,354,610)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			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

FOREST EDGE HC REHAB CTR

ID# 0052035

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	MARKETING SALARIES	\$ (87,257)	21	1
2	BANK CHARGE	(6,874)	21	2
3	NONALLOWABLE TRAVEL	(9,850)	25	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	(103,981)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FOREST EDGE HC REHAB CTR# 0052035

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	16,240	0	0	0	0	0	0	0	0	16,240	1
2	Food Purchase	(928)	0	0	0	0	0	0	0	0	0	0	(928)	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	762	169	0	0	0	0	0	0	0	0	931	5
6	Maintenance	0	1,627	360	162	0	0	0	0	0	0	0	2,149	6
7	Other (specify):*	0	0	0	642	0	0	0	0	0	0	0	642	7
8	TOTAL General Services	(928)	2,389	16,769	804	0	0	0	0	0	0	0	19,034	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	60,378	0	0	0	0	0	0	0	0	60,378	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	60,378	0	0	0	0	0	0	0	0	60,378	16
	C. General Administration													
17	Administrative	0	0	(804,000)	25,093	0	0	0	0	0	0	0	(778,907)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	147	81,884	1,408	56,842	0	0	0	0	0	0	140,281	19
20	Fees, Subscriptions & Promotions	(20,351)	75	9,631	2,291	0	0	0	0	0	0	0	(8,354)	20
21	Clerical & General Office Expenses	(95,926)	0	23,384	22,966	0	0	0	0	0	0	0	(49,576)	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	1,069	0	0	0	0	0	0	0	0	1,069	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(9,850)	0	7,709	0	0	0	0	0	0	0	0	(2,141)	25
26	Insurance-Prop.Liab.Malpractice	0	175	2,038	278	36,053	0	0	0	0	0	0	38,544	26
27	Other (specify):*	(293,449)	0	19,619	10,931	0	0	0	0	0	0	0	(262,899)	27
28	TOTAL General Administration	(419,576)	397	(658,666)	62,967	92,895	0	0	0	0	0	0	(921,983)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(420,504)	2,786	(581,519)	63,771	92,895	0	0	0	0	0	0	(842,571)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FOREST EDGE HC REHAB CTR# 0052035

Report Period Beginning:

01/01/2013 Ending:

12/31/2013

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	(18,171)	2,544	1,215	465	771,399	0	0	0	0	0	0	757,452	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,345)	1,341	297	0	707,122	0	0	0	0	0	0	706,415	32
33	Real Estate Taxes	0	4,827	1,069	0	337,382	0	0	0	0	0	0	343,278	33
34	Rent-Facility & Grounds	0	0	12,553	0	(2,394,359)	0	0	0	0	0	0	(2,381,806)	34
35	Rent-Equipment & Vehicles	0	1,360	3,826	1,859	0	0	0	0	0	0	0	7,045	35
36	Other (specify):*	0	(26,364)	0	0	81,941	0	0	0	0	0	0	55,577	36
37	TOTAL Ownership	(20,516)	(16,292)	18,960	2,324	(496,515)	0	0	0	0	0	0	(512,039)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(441,020)	(13,506)	(562,559)	66,095	(403,620)	0	0	0	0	0	0	(1,354,610)	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

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	36 OFFICE RENT	\$ 26,364	IME REALTY CORP.		\$	\$ (26,364)	1
2	V	5 UTILITIES				762	762	2
3	V	6 REPAIRS/MAINT				1,627	1,627	3
4	V	19 ACCOUNTING FEES				147	147	4
5	V	20 LICENSES & PERMITS				75	75	5
6	V	26 INSURANCE				175	175	6
7	V	30 DEPRECIATION (SL)				2,544	2,544	7
8	V	32 INTEREST				1,341	1,341	8
9	V	33 RE TAX				4,827	4,827	9
10	V	35 STORAGE FEES				1,360	1,360	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 26,364			\$ 12,858	\$ * (13,506)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	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)
15	V	17 MANAGEMENT FEES	\$ 804,000	BRIA HEALTH SERVICES , LLC		\$	\$ (804,000)
16	V	1 DIETARY SALARIES				16,240	16,240
17	V	5 UTILITIES				169	169
18	V	6 REPAIRS & MAINTENANCE				360	360
19	V	10 NURSING SALARIES				60,378	60,378
20	V	19 PROFESSIONAL FEES				81,884	81,884
21	V	20 WANT ADS , LICENSES				9,631	9,631
22	V	21 OFFICE				23,384	23,384
23	V	23 SEMINARS				1,069	1,069
24	V	25 TRANSPORTATION				7,709	7,709
25	V	26 INSURANCE				2,038	2,038
26	V	27 EMPLOYEE BENEFITS				19,619	19,619
27	V	30 DEPRECIATION S/L				1,215	1,215
28	V	32 INTEREST				297	297
29	V	33 REAL ESTATE TAX				1,069	1,069
30	V	34 OFFICE RENT				12,553	12,553
31	V	35 PUBLIC STORAGE				391	391
32	V	35 AUTO LEASE				3,435	3,435
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 804,000			\$ 241,441	\$ * (562,559)

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	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)
15	V	21 OUTSIDE CLERICAL	\$ 42,000	EKS MANAGEMENT CO.		\$	\$ (42,000)
16	V	6 CLEANING SUPPLIES				162	162
17	V	7 SCAVENGER				642	642
18	V	17 CFO SALARY-A.WEINFELD				25,093	25,093
19	V	19 PROFESSIONAL FEES				1,408	1,408
20	V	20 WANT ADS/BACKGR CKS				2,291	2,291
21	V	21 TOTAL OFFICE				64,966	64,966
22	V	26 INSURANCE				278	278
23	V	27 EMPLOYEE BENEFITS				10,931	10,931
24	V	30 DEPRECIATION (SL)				465	465
25	V	35 EQUIPMENT RENT				1,859	1,859
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 42,000			\$ 108,095	\$ * 66,095

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	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)
15	V	34 RENT	\$ 2,394,359	PRESIDENTIAL PAVILION LLC		\$	(2,394,359)
16	V	34 RENT				1,866,000	1,866,000
17	V	30 DEPREC S.L -IMP				33,431	33,431
18	V						
19	V						
20	V	34 RENT	1,866,000	BEVERLY PAVILION LLC			(1,866,000)
21	V	19 PROFESSIONAL FEES				56,842	56,842
22	V	26 INSURANCE - PROPERTY				36,053	36,053
23	V	30 DEPR S.L BUILDING & IMP				660,412	660,412
24	V	30 DEPR S.L. - EQUIP & FURN				77,556	77,556
25	V	32 INTERST				707,122	707,122
26	V	33 REAL ESTATE TAXES				337,382	337,382
27	V	36 M.I.P. INSURANCE				81,941	81,941
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 4,260,359			\$ 3,856,739	\$ * (403,620)

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	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)		
15	V		\$			\$	\$	15	
16	V							16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$			\$	0	\$ *	39

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

Facility Name & ID Number

FOREST EDGE HC REHAB CTR

0052035

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	AVRUM WEINFELD	23.75	ATRIUM HEALTHCARE & REHAB	COHOKIA	EKS MANAGEMENT	LINCOLNWOOD	HOME OFFICE	1
2								2
3	DANIEL WEISS	23.75	RIVER OAKS HEALTHCARE	BURNHAM	IME REALTY CORP	LINCOLNWOOD	MGMT CONSULT	3
4								4
5	NATAN WEISS	23.75	BELLEVILLE HEALTHCARE & REHAB	BELLEVILLE				5
6								6
7	FRED BERKOVITS	23.75	GENEVA NURSING & REHAB	GENEVA	BRIA HEALTH SERVICES, LLC	LINCOLNWOOD	MANAGEMENT	7
8								8
9	DOV SEGAL	5.00	WESTMONT NURSING & REHAB	WESTMONT				9
10					BEVERLY PAVILION		REAL ESTATE	10
11			MST HEALTH CARE PROPERTIES	SOUTH CHICAGO HEIGHTS	LLC	LINCOLNWOOD		11
12								12
13								13
14			PALOS HILLS HEALTHCARE	PALOS HILLS				14
15								15
16			LAKE PARK	WAUKEGAN				16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number FOREST EDGE HC REHAB CTR # 0052035 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

VII. RELATED PARTIES (continued)

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

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

1	2	3	4	5	6		7		8	9	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
1	ALLOCATION FR BRIA HEALTH SERVICES							\$		1	
2	DOV SEGAL	Purchasing Consult	CONSULTING	5.00			SALARY & FEE	38,497	19-7	2	
3	Fred Berkovits - Forest edge	Administrative cons	consulting	23.75	Forest Edge		FEES	42,398	19-7	3	
4		ADMINISTRATOR	Aministrator			45	64.00	FEES	129,581	17	4
5										5	
6										6	
7	ALLOCATION FR EKS MANAGEMENT :									7	
8										8	
9	AVRUM WEINFELD	CFO	FINANCIAL	23.75			SALARY	25,093	17-7	9	
10										10	
11	FLORA WEISS(ARM ENTER	O/S CONSULT	CLERICAL	0.00			consult fee	5,475	21-7	11	
12										12	
13							TOTAL	\$ 241,044		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 EDGE HC REHAB CTR

0052035 Report Period Beginning: 01/01/2013

Ending: 2/31/2013

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

Name of Related Organization IME REALTY
 Street Address 6865 N. LINCOLN
 City / State / Zip Code LINCOLNWOOD IL. 60712
 Phone Number (847)674-5795
 Fax Number (847) 674-5794

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	5	UTILITIES	RENTAL INCOME	121,840	6 FACILITIES	\$ 3,521	\$ 26,364	\$ 762	1
2	6	REPAIRS/MAINT	RENTAL INCOME	121,840	6 FACILITIES	7,519	26,364	1,627	2
3	19	ACCOUNTING FEES	RENTAL INCOME	121,840	6 FACILITIES	678	26,364	147	3
4	20	LICENSES & PERMITS	RENTAL INCOME	121,840	6 FACILITIES	345	26,364	75	4
5	26	INSURANCE	RENTAL INCOME	121,840	6 FACILITIES	807	26,364	175	5
6	30	DEPRECIATION (SL)	RENTAL INCOME	121,840	6 FACILITIES	11,757	26,364	2,544	6
7	32	INTEREST	RENTAL INCOME	121,840	6 FACILITIES	6,197	26,364	1,341	7
8	33	RE TAX	RENTAL INCOME	121,840	6 FACILITIES	22,310	26,364	4,827	8
9	35	STORAGE FEES	RENTAL INCOME	121,840	6 FACILITIES	6,286	26,364	1,360	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					\$ 59,420	\$	\$ 12,858	25

Facility Name & ID Number FOREST EDGE HC REHAB CTR

0052035 Report Period Beginning: 01/01/2013

Ending: 2/31/2013

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

Name of Related Organization BRIA HEALTH SERVICES LLC
 Street Address 6865 N. LINCOLN AVE.
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 674 - 5795
 Fax Number (847) 674 - 5794

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	1	DIETARY SALARIES	CENSUS DAYS	475,523	8 FACILITIES	\$ 77,622	\$ 77,622	99,491	\$ 16,240	1
2	5	UTILITIES	CENSUS DAYS	475,523	8 FACILITIES	806		99,491	169	2
3	6	REPAIRS & MAINTENANCE	CENSUS DAYS	475,523	8 FACILITIES	1,722		99,491	360	3
4	10	NURSING SALARIES	CENSUS DAYS	475,523	8 FACILITIES	288,582	288,582	99,491	60,378	4
5	19	PROFESSIONAL FEES	CENSUS DAYS	475,523	8 FACILITIES	391,370	100,000	99,491	81,884	5
6	20	WANT ADS , LICENSES	CENSUS DAYS	475,523	8 FACILITIES	46,030		99,491	9,631	6
7	21	OFFICE	CENSUS DAYS	475,523	8 FACILITIES	111,765	36,036	99,491	23,384	7
8	23	SEMINARS	CENSUS DAYS	475,523	8 FACILITIES	5,110		99,491	1,069	8
9	25	TRANSPORTATION	CENSUS DAYS	475,523	8 FACILITIES	36,847		99,491	7,709	9
10	26	INSURANCE	CENSUS DAYS	475,523	8 FACILITIES	9,739		99,491	2,038	10
11	27	EMPLOYEE BENEFITS	CENSUS DAYS	475,523	8 FACILITIES	93,769		99,491	19,619	11
12	30	DEPRECIATION S/L	CENSUS DAYS	475,523	8 FACILITIES	5,805		99,491	1,215	12
13	32	INTEREST	CENSUS DAYS	475,523	8 FACILITIES	1,420		99,491	297	13
14	33	REAL ESTATE TAX	CENSUS DAYS	475,523	8 FACILITIES	5,109		99,491	1,069	14
15	34	OFFICE RENT	CENSUS DAYS	475,523	8 FACILITIES	60,000		99,491	12,553	15
16	35	PUBLIC STORAGE	CENSUS DAYS	475,523	8 FACILITIES	1,868		99,491	391	16
17	35	AUTO LEASE	CENSUS DAYS	475,523	8 FACILITIES	16,418		99,491	3,435	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,153,982	\$ 502,240		\$ 241,441	25

Facility Name & ID Number FOREST EDGE HC REHAB CTR

0052035 Report Period Beginning: 01/01/2013

Ending: 2/31/2013

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

Name of Related Organization EKS MANAGEMENT
 Street Address 6865 N LINCOLN AVE
 City / State / Zip Code LICOLNWOOD IL 60712
 Phone Number (847) 674 - 5795
 Fax Number (847) 674 - 5794

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	6	CLEANING SUPPLIES	CENSUS DAYS	303,887	4 FACILITIES	\$ 495	\$ 99,491	\$ 162	1
2	7	SCAVENGER	CENSUS DAYS	303,887	4 FACILITIES	1,960	99,491	642	2
3	17	CFO SALARY-A.WEINFELD	CENSUS DAYS	303,887	4 FACILITIES	76,648	76,648	25,093	3
4	19	PROFESSIONAL FEES	CENSUS DAYS	303,887	4 FACILITIES	4,302	99,491	1,408	4
5	20	WANT ADS/BACKGR CKS	CENSUS DAYS	303,887	4 FACILITIES	7,000	99,491	2,291	5
6	21	TOTAL OFFICE	CENSUS DAYS	303,887	4 FACILITIES	198,433	139,928	64,966	6
7	26	INSURANCE	CENSUS DAYS	303,887	4 FACILITIES	848	99,491	278	7
8	27	EMPLOYEE BENEFITS	CENSUS DAYS	303,887	4 FACILITIES	33,390	99,491	10,931	8
9	30	DEPRECIATION (SL)	CENSUS DAYS	303,887	4 FACILITIES	1,420	99,491	465	9
10	35	EQUIPMENT RENT	CENSUS DAYS	303,887	4 FACILITIES	5,680	99,491	1,859	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				\$ 330,176	\$ 216,576		\$ 108,095	25

Facility Name & ID Number FOREST EDGE HC REHAB CTR

0052035 Report Period Beginning: 01/01/2013

Ending: 2/31/2013

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

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

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

FOREST EDGE HC REHAB CTR

0052035

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	Name of Lender	2		3	4	5	6		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	B.WEINFELD	X		WORKING CAPITAL	\$2,500.00	11/12	\$ 200,000	\$ 197,883	11/22	0.1409	\$ 28,035	1					
2	S.SEGAL	X		WORKING CAPITAL	\$1,590.00	11/12	150,000	137,137	11/22	0.0500	7,182	2					
3	MEMBERS -BYB	X		WORKING CAPITAL	\$5,000.00	11/12	250,000	198,495	8/17	0.0550	12,349	3					
4												4					
5												5					
	Working Capital																
6			X	INSURANCE POLICIES FIN							2,785	6					
7				L.O.C.				1,665,000			60,652	7					
8												8					
9	TOTAL Facility Related				\$9,090.00		\$ 600,000	\$ 2,198,514			\$ 111,003	9					
	B. Non-Facility Related*																
10	IRS, IDR, ETC		X	LATE FEES								10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 600,000	\$ 2,198,514			\$ 111,003	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # 36

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

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

Facility Name & ID Number

FOREST EDGE HC REHAB CTR

0052035

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	Name of Lender	2		3	4	5	6		8	9	10	11						
		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	HUD -CAMBRIDGE - BEVERLY	X		MORTGAGE	\$79,003.00	6/01/12	\$ 17,721,500	\$ 17,316,909	5/01/43	0.0395	\$ 688,730	1						
2	WEDGEWOOD	X		MORTGAGE	\$15,000.00		1,525,600	334,328	12/01/15	0.0375	18,392	2						
3												3						
4	IME - RELATED										1,341	4						
5	BRIA - RELATED										297	5						
	Working Capital																	
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$94,003.00		\$ 19,247,100	\$ 17,651,237			\$ 708,760	9						
	B. Non-Facility Related*																	
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 19,247,100	\$ 17,651,237			\$ 708,760	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 81,941 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.)

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FOREST EDGE HC REHAB CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0052035

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>20-31-108-044-0000</u>	<u>NURSING HOME</u>	\$ <u>461,188.00</u>	\$ <u>461,188.00</u>
2. _____	<u>OFFICE ALLOCATION - IME</u>	\$ _____	\$ <u>4,827.00</u>
3. _____	<u>OFFICE ALLOCATION - BRIA</u>	\$ _____	\$ <u>1,069.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>461,188.00</u></u>	\$ <u><u>467,084.00</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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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: 92,056 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 7+BASEMENT

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).

N/A

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			<u>2005</u>	<u>\$ 1,500,000</u>	1
2					2
3	TOTALS			\$ 1,500,000	3

Facility Name & ID Number **FOREST EDGE HC REHAB CTR**# **0052035**

Report Period Beginning:

01/01/2013 Ending:

12/31/2013

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	328		2005		\$ 17,449,000	\$ 634,509	27.5	\$ 634,509	\$	\$ 5,578,392	4
5											5
6											6
7		BRIA ALLOCATION			18,783	884		884			7
8		IME ALLOCATIONS			75,472	2,452		2,452			8
		Improvement Type**									
9		AWNINGS	2001		10,500	382	27.5	382		4,632	9
10		FENCE	2001		2,100	140	15	140		1,698	10
11		ELEVATOR	2001		18,340	667	27.5	667		8,087	11
12		ALARM	2001		5,686	207	27.5	207		2,510	12
13		WINDOWS	2001		4,149	151	27.5	151		1,831	13
14		BOILER	2001		3,000	109	27.5	109		1,104	14
15		FURNISHING WALLPAPER & BORDERS	2001		12,953		5			12,953	15
16		KITCHEN SINK & DRAIN	2001		2,525	92	27.5	92		1,115	16
17		DOORS	2001		15,100	549	27.5	549		6,646	17
18		ELEVATOR	2002		222,811	8,102	27.5	8,102		97,224	18
19		FENCE	2002		3,100	207	15	207		2,381	19
20		DOORS & LOCKS	2002		21,741	791	27.5	791		9,393	20
21		SHOWER ROOMS	2002		4,669	170	27.5	170		1,920	21
22		ALARM AND SPRINKLER	2002		11,881	432	27.5	432		4,877	22
23		EJECTOR & SEWEGE PUMP	2002		14,604	531	27.5	531		5,996	23
24		ROOF DRAIN	2002		3,100	113	27.5	113		1,304	24
25		FURNISHING - CARPETS AND DRAPERIES	2002		91,494		5			91,494	25
26		ELEVATOR	2003		110,562	4,020	27.5	4,020		43,383	26
27		PARKING LOT	2003		64,182	4,279	15	4,279		44,930	27
28		FIRE ALARM SYSTEM	2003		25,000	909	27.5	909		9,582	28
29		ROOF	2003		26,500	964	27.5	964		10,082	29
30		EXTERIOR WALL	2003		9,796	356	27.5	356		3,694	30
31		SINKS	2003		3,146	114	27.5	114		1,202	31
32		BUILT IN WARDROBE	2003		19,398	705	27.5	705		7,256	32
33		REBUILD A/C & HEATING RETURN FAN	2004		4,700	171	27.5	171		1,689	33
34		FIRE ALARM SYSTEM	2004		13,201	480	27.5	480		4,700	34
35		BUILT IN WARDROBE	2004		21,807	793	27.5	793		7,567	35
36		MASONRY REPAIRS	2004		61,620	2,241	27.5	2,241		20,823	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 EDGE HC REHAB CTR**# **0052035**

Report Period Beginning:

01/01/2013 Ending:

12/31/2013

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	DOORS	2004	\$ 2,995	\$ 109	27.5	\$ 109	\$	\$ 1,004	37
38	BOILER REPAIR	2004	5,650	206	27.5	206		1,862	38
39	HOT WATER HEATER	2004	5,756	209	27.5	209		2,317	39
40	FLOOR TILING	2004	5,326	194	27.5	194		1,754	40
41	REMODEL BATHROOM	2005	6,080	221	27.5	221		1,888	41
42	DOORS	2005	4,506	164	27.5	164		1,401	42
43	FLOOR TILING	2005	1,536	56	27.5	56		478	43
44	2 WATER BOILERS	2005	99,047	3,602	27.5	3,602		29,867	44
45	CONCRETE PATIO	2005	3,015	201	15	201		1,734	45
46	SHOWER	2006	3,040	111	27.5	111		837	46
47	DUCT WORK	2006	5,600	204	27.5	204		1,539	47
48	A/C COOLING TOWER	2006	13,161	479	27.5	479		3,133	48
49	FIRE ALARM - BEVERLY	2007	273,534	9,946	27.5	9,946		64,650	49
50	COOLING TOWERS - BEVERLY	2007	121,905	4,433	27.5	4,433		28,814	50
51	SHOWERS - BEVERLY	2007	12,160	442	27.5	442		2,873	51
52	AIR CLEANERS - BEVERLY	2007	10,851	395	27.5	395		2,567	52
53	CONCRETE WORK - BEVERLY	2007	5,100	185	27.5	185		1,295	53
54	SHOWERS - BEVERLY	2008	9,120	333	27.5	333		1,909	54
55	DOORS - BEVERLY	2008	4,520	164	27.5	164		977	55
56	BOLIER - BEVERLY	2008	5,295	193	27.5	193		1,053	56
57	FLOORS - BEVERLY	2008	6,260	228	27.5	228		1,207	57
58	ROOFING - BEVERLY	2008	3,800	138	27.5	138		719	58
59	EXTERIOR WALL - BEVERLY	2008	20,000	727	27.5	727		3,665	59
60	ROOFING - BEVERLY	2009	10,333	375	27.5	375		1,759	60
61	CAULK JOINTS - BEVERLY	2010	28,450	1,035	27.5	1,035		3,666	61
62	MECHANICAL ROOM - BEVERLY	2010	19,450	707	27.5	707		2,327	62
63	WELDING - BEVERLY	2010	3,587	130	27.5	130		406	63
64	ROOF - BEVERLY	2010	2,925	106	27.5	106		331	64
65	STEEL DOOR - BEVERLY	2011	1,275	46	27.5	46		128	65
66	CONTROLLE R- ANNUNCIATOR - BEVERLY	2011	6,649	242	27.5	242		676	66
67	CONCRETE - SIDEWALK - BEVERLY	2011	2,375	86	27.5	86		247	67
68	BACKFLOW REPAIR - BEVERLY	2011	4,550	165	27.5	165		364	68
69	ELECTRICAL - BEVERLY	2012	4,347	158	27.5	158		296	69
70	TOTAL (lines 4 thru 69)		\$ 19,063,118	\$ 691,510		\$ 691,510	\$	\$ 6,156,208	70

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

Facility Name & ID Number FOREST EDGE HC REHAB CTR

0052035

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 19,063,118	\$ 691,510		\$ 691,510	\$	\$ 6,156,208	1
2	VINYL FENCE AND GATE	2012	7,400	269	27.5	269		437	2
3	SOUTH ROOF FLASHING - BEVERLY	2012	4,350	158	27.5	158		244	3
4	KITCHEN IMPROVEMENT - BEVERLY	2012	2,640	96	27.5	96		140	4
5	SIDEWALK - BEVERLY	2012	2,150	78	27.5	78		114	5
6	NORTH ROOF FLASHING - BEVERLY	2012	1,950	71	27.5	71		104	6
7	SPRINKLER MODIFICATIONS	2012	17,530	637	27.5	637		770	7
8	FIRE DAMPERS, CEILING, ELECTRICAL WORK - BEVERLY	2012	49,679	1,807	27.5	1,807		2,183	8
9	COMPLETE REBUILD OF CHILLER - BEVERLY	2013	42,700	1,359	27.5	1,359		1,359	9
10	WIRING FOR SATELLITE - BEVERLY	2013	13,325	344	27.5	344		344	10
11	FIRE SPRINKLERS - BEVERLY	2013	16,686	379	27.5	379		379	11
12	BOILER REBUILD - BEVERLY	2013	8,550	143	27.5	143		143	12
13	INSTALL DOOR PACKAGE ON 3 ELEVATORS - BEVERLY	2013	36,000	273	27.5	273		273	13
14	WALK IN FREEZER NEW CONDENSING UNIT - BEVERLY	2013	7,307	55	27.5	55		55	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	COMM AWNING WITH NAME	2013	9,200	5,257	7	1,314	(3,943)	1,314	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 19,282,585	\$ 702,436		\$ 698,493	\$ (3,943)	\$ 6,164,067	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases	25,867	15,521	1,293	(14,228)	5	1,293	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	775,564	78,444	78,444				74
75	TOTALS	\$ 801,431	\$ 93,965	\$ 79,737	\$ (14,228)		\$ 1,293	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)	\$ 21,584,016	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 796,401	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 778,230	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (18,171)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,165,360	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:				\$ <u>0</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 4,231 Description: SEE SCHEDULE ATTACHED

(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	<u>SEE ATTACHED SCHEDULE</u>			<u>52,937</u>	18
19					19
20					20
21	TOTAL		\$	\$ <u>52,937</u>	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.)

<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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</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	1 Schedule V Line & Column Reference	2 Staff		3		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost						
							5	5				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	462,834	\$		\$	462,834	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				43,991				43,991	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39-3	hrs				441,948				441,948	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39-2	# of prescripts					170,027			170,027	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Inhalation Therapy Other (specify): <u>Med. Supplies</u>						22,600	4,012			<u>22,600</u> 4,012	13
14	TOTAL			\$		\$	971,373	\$	174,039	\$	1,145,412	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 EDGE HC REHAB CTR**# **0052035**Report Period Beginning: **01/01/2013**

Ending:

12/31/2013**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2013**

(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	\$ 247,740	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (180,000))	3,588,907		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	225,279		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,061,926	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	35,067		16
17	Accumulated Depreciation (book methods)	(20,778)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec Deposits)	454,366		22
23	Other(specify): Due From Presidential	65,181		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 533,836	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,595,762	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 909,340	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,730,107		29
30	Accrued Salaries Payable	254,843		30
31	Accrued Taxes Payable (excluding real estate taxes)	33,171		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,927,461	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	468,407		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)	\$ 468,407	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,395,868	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,199,894	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,595,762	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 120,828	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 120,828	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,079,066	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)	\$ 1,079,066	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)	\$ 1,199,894	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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 15,503,099	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 15,503,099	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	183,698	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 183,698	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***	2,345	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,345	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)	\$ 15,689,142	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,533,403	31
32	Health Care	4,438,925	32
33	General Administration	3,146,726	33
B. Capital Expense			
34	Ownership	2,609,672	34
C. Ancillary Expense			
35	Special Cost Centers	1,145,412	35
36	Provider Participation Fee	735,938	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,610,076	40
41	Income before Income Taxes (line 30 minus line 40)**	1,079,066	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,079,066	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 10,146,567	44
45	Private Pay - Net Inpatient Revenue	64,036	45
46	Medicare - Net Inpatient Revenue	5,286,018	46
47	Other-(specify) INSURANCE	6,478	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 15,503,099	49

****TAX RETURN PREPARED ON CASH BASIS**

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? **NO**** 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 EDGE HC REHAB CTR**

0052035

Report Period Beginning: **01/01/2013**

Ending:

12/31/2013

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,861	2,086	\$ 130,357	\$ 62.49	1
2	Assistant Director of Nursing	1,901	2,086	75,086	36.00	2
3	Registered Nurses	12,308	15,029	400,358	26.64	3
4	Licensed Practical Nurses	49,037	53,772	1,236,730	23.00	4
5	CNAs & Orderlies	116,740	125,573	1,291,407	10.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,548	11,605	131,328	11.32	8
9	Activity Director	1,877	2,086	40,671	19.50	9
10	Activity Assistants	17,166	18,067	173,705	9.61	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,942	2,086	33,371	16.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	33,054	34,912	329,753	9.45	15
16	Dishwashers					16
17	Maintenance Workers	6,733	7,514	107,794	14.35	17
18	Housekeepers	43,206	45,764	427,237	9.34	18
19	Laundry	16,097	17,367	167,338	9.64	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,558	22,651	348,795	15.40	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	4,127	4,313	48,768	11.31	31
32	Other Health C: SEE ATTACHED	35,358	37,036	645,692	17.43	32
33	Other(specify) SECURITY	24,270	25,494	239,600	9.40	33
34	TOTAL (lines 1 - 33)	397,783	427,441	\$ 5,827,990 *	\$ 13.63	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	M	\$ 16,481	1-3	35
36	Medical Director	O	12,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	15,744	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify) DENTAL	S	6,860	10-3	46
47	SOCIAL REHABILITATION		5,757	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 56,842		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

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	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	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number FOREST EDGE HC REHAB CTR

0052035

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ICLTC \$24,117
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,528 Line 10-2
- (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 X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
PRESIDENTIAL PAVILION LLC-0045526 11/01/12
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 735,938
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. \$ 33,726 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? 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. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 5%
- 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? YES
- g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (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.