FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0052035

Facility Name: FOREST EDGE HC REHAB CTR

Address: 8001 S WESTERN AVE (Number) CHICAGO (City) 60620 (Zip Code)

County: COOK

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

HFS ID Number:

Date of Initial License for Current Owners: 11/01/12

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: SANFORD BOKOR **Telephone Number:** (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) AVRUM WEINFELD
(Title) CEO

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) SANFORD BOKOR, PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number FOREST EDGE HC REHAB CTR # 0052035 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	218	Skilled (SNF)	218	79,788	1
2		Skilled Pediatric (SNF/PED)			2
3	110	Intermediate (ICF)	110	40,260	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	328	TOTALS	328	120,048	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	34,394	209	11,542	46,145	8
9	SNF/PED					9
10	ICF	64,289	86	1,176	65,551	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	98,683	295	12,718	111,696	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.04%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 11/01/12

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 53 and days of care provided 11,542

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number FOREST EDGE HC REHAB CTR # 0052035 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	390,532	55,253	14,794	460,579		460,579	1,623	462,202			1
2	Food Purchase		577,008		577,008	(29,829)	547,179	(1,761)	545,418			2
3	Housekeeping	424,987	96,378		521,365		521,365		521,365			3
4	Laundry	177,450	36,806	13,668	227,924		227,924		227,924			4
5	Heat and Other Utilities			272,574	272,574		272,574	546	273,120			5
6	Maintenance	363,894	47,435	93,665	504,994		504,994	11,113	516,107			6
7	Other (specify):*			43,657	43,657		43,657	304	43,961			7
8	TOTAL General Services	1,356,863	812,880	438,358	2,608,101	(29,829)	2,578,272	11,825	2,590,097			8
	B. Health Care and Programs											
9	Medical Director			8,000	8,000		8,000		8,000			9
10	Nursing and Medical Records	3,715,570	162,125	39,241	3,916,936		3,916,936	5,752	3,922,688			10
10a	Therapy	132,001			132,001		132,001		132,001			10a
11	Activities	222,347	49,596	4,566	276,509		276,509		276,509			11
12	Social Services	282,782		5,079	287,861		287,861		287,861			12
13	CNA Training											13
14	Program Transportation			11,317	11,317		11,317		11,317			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,352,700	211,721	68,203	4,632,624		4,632,624	5,752	4,638,376			16
	C. General Administration											
17	Administrative	55,000		584,000	639,000	20,833	659,833	(490,902)	168,931			17
18	Directors Fees											18
19	Professional Services			149,966	149,966	(20,833)	129,133	27,614	156,747			19
20	Dues, Fees, Subscriptions & Promotions			47,196	47,196		47,196	(13,836)	33,360			20
21	Clerical & General Office Expenses	434,800	32,874	64,415	532,089		532,089	(108,890)	423,199			21
22	Employee Benefits & Payroll Taxes			1,159,999	1,159,999	29,829	1,189,828		1,189,828			22
23	Inservice Training & Education			2,625	2,625		2,625	89	2,714			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			33,024	33,024		33,024	(1,933)	31,091			25
26	Insurance-Prop.Liab.Malpractice			339,634	339,634		339,634	28,616	368,250			26
27	Other (specify):*			544,721	544,721		544,721	(522,601)	22,120			27
28	TOTAL General Administration	489,800	32,874	2,925,580	3,448,254	29,829	3,478,083	(1,081,843)	2,396,240			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,199,363	1,057,475	3,432,141	10,688,979		10,688,979	(1,064,266)	9,624,713			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#: FOREST EDGE HC REHAB CTR **#0052035** **Report Period Beginning: 01/01/2012** **Ending: 12/31/2012**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	14,794	
	REPAIRS & MAINTENANCE		0	
			0	14,794
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		13,668	
			0	13,668
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		64,011	
	ELECTRICITY		132,046	
	WATER		73,962	
	CABLE TV - LOBBY		2,555	
			0	272,574
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,360	
	PAINTING & DECORATING		262	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		29,954	
	ELEVATOR MAINTENANCE & REPAIR		28,096	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		8,810	
	FIRE SERVICE		24,183	
			0	
			0	
			0	
			0	93,665
7	**OTHER**			
	SCAVENGER		42,537	
	SECURITY SERVICE		1,120	
			0	
			0	43,657
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	8,000	8,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		14,697	
	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	4,000	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL		4,800	
			0	39,241
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	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	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	4,566	
			0	4,566
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	5,079	
	SOCIAL WORKER	XVIII B 45-2	0	
				5,079
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number FOREST EDGE HC REHAB CTR **#0052035** **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		11,317	11,317
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	584,000	584,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	23,768	
	ADMINISTRATIVE CONSULTANTS	XIX C	20,833	
	PROFESSIONAL FEES	XIX C	105,365	
			0	149,966
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	11,765	
	EMPLOYEE WANT ADS	XIX F	0	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	10,186	
	LICENSES & PERMITS	XIX F	8,193	
	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	7,952	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	9,100	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				47,196
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,068	
	EQUIPMENT REPAIR & MAINTENANCE		8,120	
	OUTSIDE CLERICAL SERVICES		31,936	
	PENALTIES / OVERDRAFT CHARGES	VI 18	1,876	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		21,415	
	MESSENGER SERVICE		0	
			0	64,415

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	463,327	
	UNEMPLOYMENT COMPENSATION	XIX D	88,869	
	WORKERS COMPENSATION INSURANC	XIX D	217,503	
	HOSPITALIZATION INSURANCE	XIX D	310,381	
	EMPLOYEE BENEFITS - OTHER	XIX D	7,370	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	66,194	
	CHICAGO HEAD TAX	XIX D	6,355	
			0	1,159,999
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,625	
				2,625
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		33,024	
				33,024
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		339,634	
				339,634
27	**OTHER**			
	BAD DEBTS	VI 24	544,721	
				544,721

GRAND TOTAL COLUMN 3 OTHER **3,432,141**

FOREST EDGE HC REHAB CTR
SCHEDULES
12/31/2012

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

TOTAL FOOD PURCHASE	577,008
LESS SALES TAX	(1,761)
NET FOOD	575,247
TOTAL PATIENT CENSUS	111,696
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	335,088
ADD # EMPLOYEE MEALS/DAY	50
TIMES # DAYS	366
TOTAL EMPLOYEE MEALS	18,300
PATIENT MEALS	335,088
ADD EMPLOYEE MEALS	18,300
TOTAL MEALS/YEAR	353,388
NET FOOD	575,247
DIVIDE TOTAL MEALS/YEAR	353,388
COST PER MEAL	1.63
TIMES EMPLOYEE MEALS	18,300
EMPLOYEE MEAL RECLASSIFICATION	**29,829**

Facility Name & ID Number FOREST EDGE HC REHAB CTR #0052035 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			92,589	92,589		92,589	704,682	797,271			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			201,475	201,475		201,475	799,214	1,000,689			32
33	Real Estate Taxes							569,689	569,689			33
34	Rent-Facility & Grounds			1,955,500	1,955,500		1,955,500	(1,954,387)	1,113			34
35	Rent-Equipment & Vehicles			62,013	62,013		62,013	5,103	67,116			35
36	Other (specify):* **OFFICE RENT**			26,184	26,184		26,184	65,302	91,486			36
37	**TOTAL Ownership**			2,337,761	2,337,761		2,337,761	189,603	2,527,364			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		128,649	849,604	978,253		978,253		978,253			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			1,098,984	1,098,984		1,098,984		1,098,984			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		128,649	1,948,588	2,077,237		2,077,237		2,077,237			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,199,363	1,186,124	7,718,490	15,103,977		15,103,977	(874,663)	14,229,314			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: 01/01/2012 Ending: 12/31/2012

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(30,702)	30		9
10	Interest and Other Investment Income	(283)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,761)	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	(1,876)	21		18
19	Entertainment		20		19
20	Contributions	(7,952)	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	(544,721)	27		24
25	Fund Raising, Advertising and Promotional	(11,765)	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 SEE PAGE 5A	(157,731)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (756,791)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(117,872)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (117,872)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (874,663)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		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

FOREST EDGE HC REHAB CTR

ID# 0052035

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ (147,316)	21	1
2	BANK CHARGE	(1,068)	21	2
3	MARKETING AUTO LEASE	(1,165)	35	3
4	NONALLOWABLE TRAVEL	(6,000)	25	4
5	ADDITIONAL OFFICE RENT	(2,182)	36	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**	(157,731)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FOREST EDGE HC REHAB CTR # 0052035 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	1,623	0	0	0	0	0	1,623	1
2	Food Purchase	(1,761)	0	0	0	0	0	0	0	0	0	0	(1,761)	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	546	0	0	0	0	0	0	0	0	0	546	5
6	Maintenance	0	1,265	6,598	3,250	0	0	0	0	0	0	0	11,113	6
7	Other (specify):*	0	0	0	304	0	0	0	0	0	0	0	304	7
8	**TOTAL General Services**	(1,761)	1,811	6,598	3,554	0	1,623	0	0	0	0	0	11,825	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	5,752	0	0	0	0	0	5,752	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	5,752	0	0	0	0	0	5,752	16
	C. General Administration													
17	Administrative	0	0	(377,049)	20,147	0	(134,000)	0	0	0	0	0	(490,902)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	119	1,976	11,180	12,500	1,839	0	0	0	0	0	27,614	19
20	Fees, Subscriptions & Promotions	(19,717)	78	0	3,346	0	2,457	0	0	0	0	0	(13,836)	20
21	Clerical & General Office Expenses	(150,260)	0	14,421	25,065	0	1,884	0	0	0	0	0	(108,890)	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	89	0	0	0	0	0	89	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(6,000)	0	459	3,184	0	424	0	0	0	0	0	(1,933)	25
26	Insurance-Prop.Liab.Malpractice	0	130	2,520	777	25,076	113	0	0	0	0	0	28,616	26
27	Other (specify):*	(544,721)	0	10,890	9,367	0	1,863	0	0	0	0	0	(522,601)	27
28	**TOTAL General Administration**	(720,698)	327	(346,783)	73,066	37,576	(125,331)	0	0	0	0	0	(1,081,843)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(722,459)	2,138	(340,185)	76,620	37,576	(117,956)	0	0	0	0	0	(1,064,266)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FOREST EDGE HC REHAB CTR # 0052035 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(30,702)	2,117	0	518	732,749	0	0	0	0	0	0	704,682	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(283)	2,873	0	0	796,624	0	0	0	0	0	0	799,214	32
33	Real Estate Taxes	0	4,643	0	0	565,046	0	0	0	0	0	0	569,689	33
34	Rent-Facility & Grounds	0	0	0	0	(1,955,500)	1,113	0	0	0	0	0	(1,954,387)	34
35	Rent-Equipment & Vehicles	(1,165)	1,123	1,102	3,932	0	111	0	0	0	0	0	5,103	35
36	Other (specify):*	(2,182)	(24,002)	0	0	91,486	0	0	0	0	0	0	65,302	36
37	TOTAL Ownership	(34,332)	(13,246)	1,102	4,450	230,405	1,224	0	0	0	0	0	189,603	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)	(756,791)	(11,108)	(339,083)	81,070	267,981	(116,732)	0	0	0	0	0	(874,663)	45

Facility Name & ID Number FOREST EDGE HC REHAB CTR # 0052035 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	36	OFFICE RENT	$ 24,002	IME REALTY CORP.		$	$ (24,002)	1
2	V	5	UTILITIES				546	546	2
3	V	6	REPAIRS/MAINT				1,265	1,265	3
4	V	19	ACCOUNTING FEES				119	119	4
5	V	20	LICENSES & PERMITS				78	78	5
6	V	26	INSURANCE				130	130	6
7	V	30	DEPRECIATION (SL)				2,117	2,117	7
8	V	32	INTEREST				2,873	2,873	8
9	V	33	RE TAX				4,643	4,643	9
10	V	35	STORAGE FEES				1,123	1,123	10
11	V								11
12	V								12
13	V								13
14	Total			$ 24,002			$ 12,894	$ * (11,108)	14

*** 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: 01/01/2012 Ending: 12/31/2012

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 450,000	EMI ENTERPRISES, INC		$	$ (450,000)	15
16	V	6	DRIVERS SALARIES				6,598	6,598	16
17	V	17	OFFICER SALARIES				42,056	42,056	17
18	V	17	REGIONAL DIRECTOR				701	701	18
19	V	17	MANAGEMENT CONSULTANT				30,194	30,194	19
20	V	19	ACCOUNTING FEES				1,976	1,976	20
21	V	21	TOTAL OFFICE				14,421	14,421	21
22	V	25	TRANSPORTATION				459	459	22
23	V	26	INSURANCE				2,520	2,520	23
24	V	27	EMPLOYEE BENEFITS				10,890	10,890	24
25	V	35	AUTO LEASE				1,102	1,102	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			$ 450,000			$ 110,917	$ * (339,083)	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: 01/01/2012 Ending: 12/31/2012

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	OUTSIDE CLERICAL	$ 31,936	EKS MANAGEMENT CO.		$	$ (31,936)	15
16	V	6	PAINTERS SALARIES				3,250	3,250	16
17	V	7	SCAVENGER				304	304	17
18	V	17	CFO SALARY-A.WEINFELD				20,147	20,147	18
19	V	19	PROFESSIONAL FEES				11,180	11,180	19
20	V	20	WANT ADS/BACKGR CKS				3,346	3,346	20
21	V	21	TOTAL OFFICE				57,001	57,001	21
22	V	25	TRANSPORTATION				3,184	3,184	22
23	V	26	INSURANCE				777	777	23
24	V	27	EMPLOYEE BENEFITS				9,367	9,367	24
25	V	30	DEPRECIATION (SL)				518	518	25
26	V	35	EQUIPMENT RENT				3,932	3,932	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			$ 31,936			$ 113,006	$ * 81,070	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: 01/01/2012 Ending: 12/31/2012

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 1,955,500	BEVERLY PAVILION LLC		$	$ (1,955,500)	15
16	V	19	PROFESSIONAL FEES				12,500	12,500	16
17	V	26	INSURANCE				25,076	25,076	17
18	V	30	DEPR S.L BUILDING & IMP				655,193	655,193	18
19	V	30	DEPR S.L. - EQUIP & FURN				77,556	77,556	19
20	V	32	INTERST				796,624	796,624	20
21	V	33	REAL ESTATE TAXES				565,046	565,046	21
22	V	36	M.I.P. INSURANCE				91,486	91,486	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			$ 1,955,500			$ 2,223,481	$ * 267,981	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: 01/01/2012 Ending: 12/31/2012

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 134,000	BRIA HEALTH SERVICES, LLC		$	$ (134,000)	15
16	V	1	DIETARY SALARIES				1,623	1,623	16
17	V	10	NURSING SALARIES				5,752	5,752	17
18	V	19	PROFESSIONAL FEES				1,839	1,839	18
19	V	20	WANT ADS				467	467	19
20	V	21	TOTAL OFFICE				1,331	1,331	20
21	V	21	CLERICAL SALARIES				553	553	21
22	V	23	SEMINARS				89	89	22
23	V	25	TRANSPORTATIONAL STAFF				424	424	23
24	V	26	INSURANCE				113	113	24
25	V	27	EMPLOYEE BENEFITS				1,863	1,863	25
26	V	34	OFFICE RENT				1,113	1,113	26
27	V	35	AUTO LEASE				111	111	27
28	V	20	LICENSES FEES				1,990	1,990	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			$ 134,000			$ 17,268	$ * (116,732)	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: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	AVRUM WEINFELD	23.75	ATRIUM HEALTHCARE & REHAB	COHOKIA	EKS MANAGEMENT	LINCOLNWOOD	HOME OFFICE	2
3								3
4	DANIEL WEISS	23.75	RIVER OAKS HEALTHCARE	BURNHAM	IME REALTY CORP	LINCOLNWOOD	MGMT CONSULT	4
5								5
6	NATAN WEISS	23.75	BELLEVILLE HEALTHCARE & REHAB	BELLEVILLE	EMI ENTERPRISES	LINCOLNWOOD	MANAGEMENT	6
7								7
8	FRED BERKOVITS	23.75	GENEVA NURSING & REHAB	GENEVA	BRIA HEALTH		MANAGEMENT	8
9					SERVICES, LLC	LINCOLNWOOD		9
10	DOV SEGAL	5.00	WESTMONT NURSING & REHAB	WESTMONT				10
11					BEVERLY PAVILION		REAL ESTATE	11
12			MST HEALTH CARE PROPERTIES	SOUTH CHICAGO	LLC	LINCOLNWOOD		12
13				HEIGHTS				13
14								14
15			PALOS HILLS HEALTHCARE	PALOS HILLS				15
16								16
17			LAKE PARK	WAUKEGAN				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: 01/01/2012 Ending: 12/31/2012

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	
						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 EMI ENTERPRISE:								$		1
2	MORRIS ESFORMES	PRESIDENT	MGMT	0.00	SEE	6	7.50	SALARY	42,056	17-7	2
3	MICHAEL ROSEN	REG. DIRECTOR	Administrative	0.00	ATTACHED	10	14.92	SALARY	701	17-7	3
4	PHILIP ESFORMES	ADM CON	Administrative	0.00	SCHEDULE	5	7.58	consult. Fee	30,194	17-7	4
5	ALLOCATION FR EKS MANAGEMENT :										5
6	AVRUM WEINFELD	CFO	FINANCIAL	23.75		3	4.62	SALARY	20,147	17-7	6
7	FLORA WEISS	O/S CONSULT	BOOKKEEPING	0.00		0.5	0.89	consult fee	2,681	21-7	7
8	ALLOCATIOM FR BRIA HEALTH SERVICES										8
9	DOV SEGAL	Purchasing Consult	CONSULTING	5.00				SALARY	1,823	19-7	9
10											10
11	Fred Berkovits -presidential	Aministrator	Administator - non owner		Presidential			salary	55,000	17-1	11
12	Fred Berkovits - Forest edge	administrator	Aministrator	23.75	Forest Edge				20,833	17-7	12
13								TOTAL	$ 173,435		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: 01/01/2012 Ending: 2/31/2012

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 [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	DRIVERS SALARY	PATIENT DAYS	434,638	13	$ 30,591	$ 30,591	93,740	$ 6,598	1
2	17	OFFICER SALARY	PATIENT DAYS	434,638	13	195,000	195,000	93,740	42,056	2
3	17	REGIONAL DIRECTOR	PATIENT DAYS	434,638	13	3,250	3,250	93,740	701	3
4	17	MGT CONSULTANT	PATIENT DAYS	434,638	13	140,001		93,740	30,194	4
5	19	ACCUNTING FEES	PATIENT DAYS	434,638	13	9,162		93,740	1,976	5
6	21	TOTAL OFFICE	PATIENT DAYS	434,638	13	66,865	41,917	93,740	14,421	6
7	25	TRANSPORTATION	PATIENT DAYS	434,638	13	2,127		93,740	459	7
8	26	INSURANCE	PATIENT DAYS	434,638	13	11,682		93,740	2,520	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	434,638	13	50,493		93,740	10,890	9
10	35	AUTO LEASE	PATIENT DAYS	434,638	13	5,109		93,740	1,102	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					$ 514,280	$ 270,758		$ 110,917	25

Facility Name & ID Number FOREST EDGE HC REHAB CTR # 0052035 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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 [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	PAINTERS SALARIES	PATIENT DAYS	584,290	16	$ 17,002	$ 17,002	111,696	$ 3,250	1
2	7	SCAVENGER	PATIENT DAYS	584,290	16	1,589		111,696	304	2
3	17	CFO SALARY-A.WEINFELD	PATIENT DAYS	584,290	16	105,390	105,390	111,696	20,147	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	584,290	16	58,487	48,494	111,696	11,181	4
5	20	WANT ADS/BACKGR CKS	PATIENT DAYS	584,290	16	17,500		111,696	3,345	5
6	21	TOTAL OFFICE	PATIENT DAYS	584,290	16	298,180	206,170	111,696	57,002	6
7	25	TRANSPORTATION	PATIENT DAYS	584,290	16	16,652		111,696	3,183	7
8	26	INSURANCE	PATIENT DAYS	584,290	16	4,061		111,696	776	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	584,290	16	48,997		111,696	9,367	9
10	30	DEPRECIATION (SL)	PATIENT DAYS	584,290	16	2,710		111,696	518	10
11	35	EQUIPMENT RENT	PATIENT DAYS	584,290	16	20,572		111,696	3,933	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					$ 591,140	$ 377,056		$ 113,006	25

Facility Name & ID Number FOREST EDGE HC REHAB CTR # 0052035 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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 [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674 - 1946
Fax Number: (847) 674 - 1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	193,277	14	$ 4,400	$	24,002	$ 546	1
2	6	REPAIRS / MAINTENCE	RENTAL INCOME	193,277	14	10,190		24,002	1,265	2
3	19	ACCOUNTING FEES	RENTAL INCOME	193,277	14	962		24,002	119	3
4	20	LICENSE & PERMITS	RENTAL INCOME	193,277	14	632		24,002	78	4
5	26	INSURANCE	RENTAL INCOME	193,277	14	1,045		24,002	130	5
6	30	SL DEPRECIATION	RENTAL INCOME	193,277	14	17,044		24,002	2,117	6
7	32	INTEREST	RENTAL INCOME	193,277	14	23,132		24,002	2,873	7
8	33	REAL ESTATE TAX	RENTAL INCOME	193,277	14	37,391		24,002	4,643	8
9	35	STORAGE FEES	RENTAL INCOME	193,277	14	9,043		24,002	1,123	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					$ 103,839	$		$ 12,894	25

Facility Name & ID Number FOREST EDGE HC REHAB CTR # 0052035 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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 [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT CENSUS	322,729	8	$ 29,170	$ 29,170	17,956	$ 1,623	1
2	10	NURSING SALARIES	PATIENT CENSUS	322,729	8	103,388	103,388	17,956	5,752	2
3	19	PROFESSIONAL FEES	PATIENT CENSUS	322,729	8	33,054	32,765	17,956	1,839	3
4	20	WANT ADS	PATIENT CENSUS	322,729	8	8,400		17,956	467	4
5	21	TOTAL OFFICE	PATIENT CENSUS	322,729	8	23,931		17,956	1,331	5
6	21	CLERICAL SALARIES	PATIENT CENSUS	322,729	8	9,940	9,940	17,956	553	6
7	23	SEMINARS	PATIENT CENSUS	322,729	8	1,599		17,956	89	7
8	25	TRANSPORTATIONAL STAFF	PATIENT CENSUS	322,729	8	7,616		17,956	424	8
9	26	INSURANCE	PATIENT CENSUS	322,729	8	2,036		17,956	113	9
10	27	EMPLOYEE BENEFITS	PATIENT CENSUS	322,729	8	33,481		17,956	1,863	10
11	34	OFFICE RENT	PATIENT CENSUS	322,729	8	20,000		17,956	1,113	11
12	35	AUTO LEASE	PATIENT CENSUS	322,729	8	2,000		17,956	111	12
13	20	LICENSES FEES	PATIENT CENSUS	35,314	2	3,980		17,956	1,990	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					$ 278,595	$ 175,263		$ 17,268	25

Facility Name & ID Number FOREST EDGE HC REHAB CTR # 0052035 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	B.WEINFELD	X		WORKING CAPITAL	$2,500.00	11/12	$ 200,000	$ 199,848	11/22	0.1409	$ 2,348	1
2	S.SEGAL	X		WORKING CAPITAL	$1,590.00	11/12	150,000	149,035	11/22	0.0500	625	2
3	MEMBERS -BYB	X		WORKING CAPITAL	$5,000.00	11/12	250,000	246,146	8/17	0.0550	1,146	3
4	MEMBERS LOANS	X		WORKING CAPITAL				3,520,693			111,083	4
5												5
	Working Capital											
6	MB FINANCIAL		X	WORKING CAPITAL	INTEREST	REVOLV	900,000	900,000	REVOLVE		4,975	6
7	MB FINANCIAL		X	WORKING CAPITAL	INTEREST	REVOLV		1,620,000	REVOLVE		77,722	7
8			X	INSURANCE POLICIES FIN							3,576	8
9	TOTAL Facility Related				$9,090.00		$ 1,500,000	$ 6,635,722			$ 201,475	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,500,000	$ 6,635,722			$ 201,475	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: 01/01/2012 Ending: 12/31/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HUD - BEVERLY		X	MORTGAGE	$99,236.00	5/05	$ 18,706,800	$		0.0540	$ 295,877	1
2	HUD - BEVERLY		X	MORTGAGE	$79,003.00	6/12	17,721,500	16,768,379	5/43	0.0395	474,471	2
3	WEDGEWOOD		X	MORTGAGE	$15,000.00		1,525,600	649,264	12/15	0.0375	26,276	3
4	IME - RELATED										2,873	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$193,239.00		$ 37,953,900	$ 17,417,643			$ 799,497	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 37,953,900	$ 17,417,643			$ 799,497	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 91,486** **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: 01/01/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 601,964	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.)		$ 582,005	2
3. Under or (over) accrual (line 2 minus line 1).		$ (19,959)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 585,005	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.		$ 565,046	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	388,573	8
	2008	392,472	9
	2009	560,054	10
	2010	584,436	11
	2011	582,005	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2011 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FOREST EDGE HC REHAB CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0052035

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	20-31-108-044-0000	NURSING HOME	$ 582,005.24	$ 582,005.24
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 582,005.24	$ 582,005.24

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

Facility Name & ID Number FOREST EDGE HC REHAB CTR # 0052035 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			2005	$ 1,500,000	1
2					2
3	TOTALS			$ 1,500,000	3

Facility Name & ID Number FOREST EDGE HC REHAB CTR # 0052035 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	328		2005		$ 17,449,000	$ 634,509	27.5	$ 634,509	$	$ 4,943,883	4
5											5
6											6
7											7
8	IME ALLOCATIONS				75,472	1,998		1,998			8
	Improvement Type**										
9	AWNINGS			2001	10,500	382	27.5	382		4,250	9
10	FENCE			2001	2,100	140	15	140		1,558	10
11	ELEVATOR			2001	18,340	667	27.5	667		7,420	11
12	ALARM			2001	5,686	207	27.5	207		2,303	12
13	WINDOWS			2001	4,149	151	27.5	151		1,680	13
14	BOILER			2001	3,000	109	27.5	109		995	14
15	FURNISHINGWALLPAPER & BORDERS			2001	12,953		5			12,953	15
16	KITCHEN SINK & DRAIN			2001	2,525	92	27.5	92		1,023	16
17	DOORS			2001	15,100	549	27.5	549		6,097	17
18	ELEVATOR			2002	222,811	8,102	27.5	8,102		89,122	18
19	FENCE			2002	3,100	207	15	207		2,174	19
20	DOORS & LOCKS			2002	21,741	791	27.5	791		8,602	20
21	SHOWER ROOMS			2002	4,669	170	27.5	170		1,750	21
22	ALARM AND SPRINKLER			2002	11,881	432	27.5	432		4,445	22
23	EJECTOR & SEWEGE PUMP			2002	14,604	531	27.5	531		5,465	23
24	ROOF DRAIN			2002	3,100	113	27.5	113		1,191	24
25	FURNISHING - CARPETS AND DRAPERIES			2002	91,494		5			91,494	25
26	ELEVATIR			2003	110,562	4,020	27.5	4,020		39,363	26
27	PARKING LOT			2003	64,182	4,279	15	4,279		40,651	27
28	FIRE ALARM SYSTEM			2003	25,000	909	27.5	909		8,673	28
29	ROOF			2003	26,500	964	27.5	964		9,118	29
30	EXTERIOR WALL			2003	9,796	356	27.5	356		3,338	30
31	SINKS			2003	3,146	114	27.5	114		1,088	31
32	BUILT IN WARDROBE			2003	19,398	705	27.5	705		6,551	32
33	REBUILD A/C & HEATING RETURN FAN			2004	4,700	171	27.5	171		1,518	33
34	FIRE ALARM SYSTEM			2004	13,201	480	27.5	480		4,220	34
35	BUILT IN WARDROBE			2004	21,807	793	27.5	793		6,774	35
36	MASONRY REPAIRS			2004	61,620	2,241	27.5	2,241		18,582	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: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DOORS	2004	$ 2,995	$ 109	27.5	$ 109	$	$ 895	37
38	BOILER REPAIR	2004	5,650	206	27.5	206		1,656	38
39	HOT WATER HEATER	2004	5,756	209	27.5	209		2,108	39
40	FLOOR TILING	2004	5,326	194	27.5	194		1,560	40
41	REMODEL BATHROOM	2005	6,080	221	27.5	221		1,667	41
42	DOORS	2005	4,506	164	27.5	164		1,237	42
43	FLOOR TILING	2005	1,536	56	27.5	56		422	43
44	2 WATER BOILERS	2005	99,047	3,602	27.5	3,602		26,265	44
45	CONCRETE PATIO	2005	3,015	201	15	201		1,533	45
46	SHOWER	2006	3,040	111	27.5	111		726	46
47	DUCT WORK	2006	5,600	204	27.5	204		1,335	47
48	A/C COOLING TOWER	2006	13,161	479	27.5	479		2,654	48
49	FIRE ALARM - BEVERLY	2007	273,534	9,946	27.5	9,946		54,704	49
50	COOLING TOWERS - BEVERLY	2007	121,905	4,433	27.5	4,433		24,381	50
51	SHOWERS - BEVERLY	2007	12,160	442	27.5	442		2,431	51
52	AIR CLEANERS - BEVERLY	2007	10,851	395	27.5	395		2,172	52
53	CONCRETE WORK - BEVERLY	2007	5,100	185	27.5	185		1,110	53
54	SHOWERS - BEVERLY	2008	9,120	333	27.5	333		1,576	54
55	DOORS - BEVERLY	2008	4,520	164	27.5	164		813	55
56	BOLIER - BEVERLY	2008	5,295	193	27.5	193		860	56
57	FLOORS - BEVERLY	2008	6,260	228	27.5	228		979	57
58	ROOFING - BEVERLY	2008	3,800	138	27.5	138		581	58
59	EXTERIOR WALL - BEVERLY	2008	20,000	727	27.5	727		2,938	59
60	ROOFING - BEVERLY	2009	10,333	375	27.5	375		1,384	60
61	CAULK JOINTS - BEVERLY	2010	28,450	1,035	27.5	1,035		2,631	61
62	MECHANICAL ROOM - BEVERLY	2010	19,450	707	27.5	707		1,620	62
63	WELDING - BEVERLY	2010	3,587	130	27.5	130		276	63
64	ROOF - BEVERLY	2010	2,925	106	27.5	106		225	64
65	STEEL DOOR - BEVERLY	2011	1,275	46	27.5	46		82	65
66	CONTROLLE R- ANNUNCIATOR - BEVERLY	2011	6,649	242	27.5	242		434	66
67	CONCRETE - SIDEWALK - BEVERLY	2011	2,375	86	27.5	86		161	67
68	BACKFLOW REPAIR - BEVERLY	2011	4,550	165	27.5	165		199	68
69	ELECTRICAL - BEVERLY	2012	4,347	138	27.5	138		138	69
70	TOTAL (lines 4 thru 69)		$ 19,044,335	$ 690,152		$ 690,152	$	$ 5,468,034	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: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 19,044,335	$ 690,152		$ 690,152	$	$ 5,468,034	1
2	VINYL FENCE AND GATE	2012	7,400	138	27.5	138		138	2
3	SOUTH ROOF FLASHING - BEVERLY	2012	4,350	86	27.5	86		86	3
4	KITCHEN IMPROVEMENT - BEVERLY	2012	2,640	44	27.5	44		44	4
5	SIDEWALK - BEVERLY	2012	2,150	36	27.5	36		36	5
6	NORTH ROOF FLASHING - BEVERLY	2012	1,950	33	27.5	33		33	6
7	SPRINKLER MODIFICATIONS	2012	17,530	133	27.5	133		133	7
8	FIRE DAMPERS, CEILING, ELECTRICAL WORK - BEVERLY	2012	49,679		27.5	903	903	903	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	TOTAL (lines 1 thru 33)		$ 19,130,034	$ 690,622		$ 691,525	$ 903	$ 5,469,407	34

**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: 01/01/2012 Ending: 12/31/2012

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	$ 272,920	$ 59,158	$ 27,553	$ (31,605)	10 yrs	$ 254,363	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	323,568					323,568	73
74	RELATED PARTY	775,563	78,193	78,193				74
75	TOTALS	$ 1,372,051	$ 137,351	$ 105,746	$ (31,605)		$ 577,931	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)	$ 22,002,085	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 827,973	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 797,271	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (30,702)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,047,338	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.

Facility Name & ID Number FOREST EDGE HC REHAB CTR # 0052035 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-RELATED PARTY
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								5
6								6
7	TOTAL				$ **			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: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	$
13.	/2014	$
14.	/2015	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 11,164 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	SEE ATTACHED SCHEDULE			50,849	18
19					19
20					20
21	TOTAL		$	$ 50,849	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.

Facility Name & ID Number FOREST EDGE HC REHAB CTR # 0052035 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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.

Facility Name & ID Number FOREST EDGE HC REHAB CTR # 0052035 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 417,956	$		$ 417,956	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,953			1,953	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			389,595			389,595	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 prescrpts				124,396		124,396	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): Med. Supplies					40,100	4,253		40,100 4,253	13
14	TOTAL			$		$ 849,604	$ 128,649		$ 978,253	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: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (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	$ 476,995	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (1,459,140))	5,962,963		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	234,316		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	300,303		8
9	Other(specify): Exchange	7,500		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,982,077	$	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	858,930		15
16	Equipment, at Historical Cost	700,935		16
17	Accumulated Depreciation (book methods)	(1,013,450)		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 (spe DEPOSIT ON ASSET	4,600		22
23	Other(specify): SEC754 BASIS ADJ -NET	1,492,969		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,043,984	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,026,061	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 921,978	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,581,514		29
30	Accrued Salaries Payable	279,196		30
31	Accrued Taxes Payable (excluding real estate taxes)	37,502		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)**	$ 3,820,190	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due To MEMBERS	4,054,208		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,054,208	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,874,398	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,151,663	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,026,061	$	48

***(See instructions.)**

Facility Name & ID Number FOREST EDGE HC REHAB CTR # 0052035 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 48,745	1
2	Restatements (describe):		2
3		(11,230)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 37,515	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,594,148	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	(1,480,000)	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)**	$ 1,114,148	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)**	$ 1,151,663	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number FOREST EDGE HC REHAB CTR # 0052035 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 17,498,291	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 17,498,291	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	198,287	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 198,287	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***	283	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 283	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)**	$ 17,696,861	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,608,101	31
32	Health Care	4,632,624	32
33	General Administration	3,448,254	33
	B. Capital Expense		
34	Ownership	2,337,761	34
	C. Ancillary Expense		
35	Special Cost Centers	978,253	35
36	Provider Participation Fee	1,098,984	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	(1,264)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,102,713	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,594,148	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,594,148	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 12,809,797	44
45	Private Pay - Net Inpatient Revenue	42,628	45
46	Medicare - Net Inpatient Revenue	4,506,117	46
47	Other-(specify) Insurance	139,749	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 17,498,291	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: 01/01/2012 Ending: 12/31/2012

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,954	2,091	$ 130,714	$ 62.51	1
2	Assistant Director of Nursing	1,930	2,091	75,291	36.01	2
3	Registered Nurses	10,227	12,099	311,537	25.75	3
4	Licensed Practical Nurses	54,735	59,061	1,344,916	22.77	4
5	CNAs & Orderlies	132,559	144,907	1,517,308	10.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,121	11,303	132,001	11.68	8
9	Activity Director	1,983	2,096	39,252	18.73	9
10	Activity Assistants	17,823	19,475	183,095	9.40	10
11	Social Service Workers	20,427	21,603	282,782	13.09	11
12	Dietician					12
13	Food Service Supervisor	1,992	2,097	31,703	15.12	13
14	Head Cook					14
15	Cook Helpers/Assistants	33,418	36,871	358,829	9.73	15
16	Dishwashers					16
17	Maintenance Workers	7,300	7,848	109,295	13.93	17
18	Housekeepers	42,278	45,612	424,987	9.32	18
19	Laundry	15,794	18,233	177,450	9.73	19
20	Administrator	1,638	1,760	55,000	31.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	29,128	30,248	417,436	13.80	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	3,949	4,172	46,834	11.23	31
32	Other Health C: SEE ATTACHED	13,377	13,829	288,970	20.90	32
33	Other(specify) SEE ATTACHED	27,363	28,576	271,963	9.52	33
34	TOTAL (lines 1 - 33)	427,996	463,972	$ 6,199,363 *	$ 13.36	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 14,794	1-3	35
36	Medical Director	O	8,000	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	4,566	11-3	44
45	Social Service Consultant	E	5,079	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 48,183		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number FOREST EDGE HC REHAB CTR # 0052035 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
FRED BERKOVITS	ADMINISTRATOR	23.75	$ 55,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 55,000

B. Administrative - Other

Description	Amount
EMI- MANAGEMENT FEE	$ 450,000
BRIA HEALTHCARE SERVICES - MANAGEMENT FEE	134,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 584,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		149,966
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 149,966

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 217,503
Unemployment Compensation Insurance	88,869
FICA Taxes	463,327
Employee Health Insurance	310,381
Employee Meals	29,829
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	7,370
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	66,194
CHICAGO HEAD TAX	6,355
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,189,828

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	0
Health Care Worker Background Check	9,100
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	7,952
MARKETING/ADV/PROMO	11,765
LICENSES/DUES/SUBSCRIPTIONS	18,379
MGMT CO ALLOC	5,881
TRUST/FRANCHISE/CONTRIB/ETC	(7,952)
Less: Public Relations Expense	(0)
Non-allowable advertising	(11,765)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,360

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number FOREST EDGE HC REHAB CTR # 0052035 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8							N/A						
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: 01/01/2012 Ending: 12/31/2012

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 $ 10,186**

(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. $ 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. $ ########
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. $ **29,829** 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.