

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0051516 Facility Name: Forest View Rehab & Nrsg Ctr Address: 535 South Elm Itasca 60143 Number City Zip Code County: Dupage Telephone Number: (708) 449-1900 Fax #: (708) 449-1500 HFS ID Number: Date of Initial License for Current Owners: 06/01/11 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. X Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Daniel S. Gaafar Telephone Number: (317) 237-5500 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 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. Officer or Administrator of Provider (Signed) (Type or Print Name) Flora Reznik (Title) CFO Paid Preparer (Signed) (Print Name and Title) Daniel S. Gaafar Partner (Firm Name & Address) Bradley Associates 201 S. Capitol Ave, Suite 700, Indianapolis, IN 46225 (Telephone) (317) 237-5500 Fax #: (317) 237-5503 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
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Facility Name & ID Number Forest View Rehab & Nrsg Ctr

0051516 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>76</u>	Skilled (SNF)	<u>76</u>	<u>27,816</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>68</u>	Intermediate (ICF)	<u>68</u>	<u>24,888</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>144</u>	TOTALS	<u>144</u>	<u>52,704</u>	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>16,800</u>	<u>1,153</u>	<u>3,486</u>	<u>21,439</u>	8
9	SNF/PED					9
10	ICF	<u>15,031</u>	<u>1,032</u>	<u>471</u>	<u>16,534</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>31,831</u>	<u>2,185</u>	<u>3,957</u>	<u>37,973</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.05%

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)
N/A

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 06/01/11

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 06/01/11 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 14 and days of care provided 2,959

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	223,092		33,256	256,348		256,348	(4,212)	252,136			1
2	Food Purchase		186,732		186,732		186,732	607	187,339			2
3	Housekeeping	188,403	23,697		212,100		212,100	384	212,484			3
4	Laundry	1,590	10,980		12,570		12,570		12,570			4
5	Heat and Other Utilities			279,511	279,511		279,511	518	280,029			5
6	Maintenance	32,158	40,337	70,057	142,552		142,552	930	143,482			6
7	Other (specify):*											7
8	TOTAL General Services	445,243	261,746	382,824	1,089,813		1,089,813	(1,773)	1,088,040			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,646,116	219,767	47,683	2,913,566		2,913,566	(33,074)	2,880,492			10
10a	Therapy			972,730	972,730		972,730		972,730			10a
11	Activities	126,761	22,467		149,228		149,228	2,437	151,665			11
12	Social Services	61,561		16,632	78,193		78,193		78,193			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacy Consult			10,251	10,251		10,251		10,251			15
16	TOTAL Health Care and Programs	2,834,438	242,234	1,065,296	4,141,968		4,141,968	(30,637)	4,111,331			16
	C. General Administration											
17	Administrative	104,319			104,319		104,319		104,319			17
18	Directors Fees											18
19	Professional Services			380,386	380,386		380,386	(139,939)	240,447			19
20	Dues, Fees, Subscriptions & Promotions			7,252	7,252		7,252	(33)	7,219			20
21	Clerical & General Office Expenses	174,835	56,808	(10,348)	221,295		221,295	189,116	410,411			21
22	Employee Benefits & Payroll Taxes			619,599	619,599		619,599	44,932	664,531			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,084	2,084		2,084	1,205	3,289			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			191,778	191,778		191,778	27,693	219,471			26
27	Other (specify):*											27
28	TOTAL General Administration	279,154	56,808	1,190,751	1,526,713		1,526,713	122,974	1,649,687			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,558,835	560,788	2,638,871	6,758,494		6,758,494	90,564	6,849,058			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			95,945	95,945		95,945	201,791	297,736			30
31	Amortization of Pre-Op. & Org.							229,964	229,964			31
32	Interest			167,093	167,093		167,093	186,737	353,830			32
33	Real Estate Taxes			64,304	64,304		64,304		64,304			33
34	Rent-Facility & Grounds			1,094,513	1,094,513		1,094,513	(1,089,221)	5,292			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,421,855	1,421,855		1,421,855	(470,729)	951,126			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,756	1,756		1,756		1,756			38
39	Ancillary Service Centers		107,076		107,076		107,076		107,076			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			266,929	266,929		266,929		266,929			42
43	Other (specify):* Bad Debt Exp.			193,682	193,682		193,682	(193,682)				43
44	TOTAL Special Cost Centers		107,076	462,367	569,443		569,443	(193,682)	375,761			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,558,835	667,864	4,523,093	8,749,792		8,749,792	(573,847)	8,175,945			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	28,073	30		9
10	Interest and Other Investment Income	(1,656)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(54)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	84,658	21		18
19	Entertainment				19
20	Contributions	(2,497)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(193,682)	43		24
25	Fund Raising, Advertising and Promotional	(15,053)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,895)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (102,106)		\$	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)	(471,741)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (471,741)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (573,847)		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

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Misc. Income	\$ (1,593)	21	1
2	Lobbying Expense	(302)	20	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,895)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(54)	(4,158)	0	0	0	0	0	0	0	0	0	(4,212)	1
2	Food Purchase	0	607	0	0	0	0	0	0	0	0	0	607	2
3	Housekeeping	0	384	0	0	0	0	0	0	0	0	0	384	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	518	0	0	0	0	0	0	0	0	0	518	5
6	Maintenance	0	930	0	0	0	0	0	0	0	0	0	930	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(54)	(1,719)	0	0	0	0	0	0	0	0	0	(1,773)	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	(33,074)	0	0	0	0	0	0	0	0	0	(33,074)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	2,437	0	0	0	0	0	0	0	0	0	2,437	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	(30,637)	0	0	0	0	0	0	0	0	0	(30,637)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(150,949)	11,010	0	0	0	0	0	0	0	0	(139,939)	19
20	Fees, Subscriptions & Promotions	(302)	269	0	0	0	0	0	0	0	0	0	(33)	20
21	Clerical & General Office Expenses	65,515	123,351	250	0	0	0	0	0	0	0	0	189,116	21
22	Employee Benefits & Payroll Taxes	0	44,932	0	0	0	0	0	0	0	0	0	44,932	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,205	0	0	0	0	0	0	0	0	0	1,205	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	317	27,376	0	0	0	0	0	0	0	0	27,693	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	65,213	19,125	38,636	0	0	0	0	0	0	0	0	122,974	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	65,159	(13,231)	38,636	0	0	0	0	0	0	0	0	90,564	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	28,073	0	173,718	0	0	0	0	0	0	0	0	201,791	30
31	Amortization of Pre-Op. & Org.	0	0	229,964	0	0	0	0	0	0	0	0	229,964	31
32	Interest	(1,656)	0	188,393	0	0	0	0	0	0	0	0	186,737	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(1,089,221)	0	0	0	0	0	0	0	0	(1,089,221)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	26,417	0	(497,146)	0	0	0	0	0	0	0	0	(470,729)	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):*	(193,682)	0	0	0	0	0	0	0	0	0	0	(193,682)	43
44	TOTAL Special Cost Centers	(193,682)	0	0	0	0	0	0	0	0	0	0	(193,682)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(102,106)	(13,231)	(458,510)	0	0	0	0	0	0	0	0	(573,847)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Michael Blisko	35%	Ambassador Nursing & Rehab Center	Chicago	Infinity	Hillside	Mgmt Co
GELP	35%	Belhaven Nursing & Rehab Center	Chicago	Forest View Realty		Realty Co
Rosie Schwartz	30%	City View Multicare Center	Cicero			
		Continental Nursing & Rehab Center	Chicago			
		Lakeview Nursing & Rehab Center	Chicago			
		Midway Neurological & Rehab Center	Bridgeview			
		Momence Meadows Nursing & Rehab Ctr	Momence			

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	1	Dietary	\$ 14,710	Infinity Healthcare Management of Illinois		\$ 10,552	\$ (4,158)	1
2	V	2	Food Purchase		Infinity Healthcare Management of Illinois		607	607	2
3	V	3	Housekeeping		Infinity Healthcare Management of Illinois		384	384	3
4	V	5	Utilities		Infinity Healthcare Management of Illinois		518	518	4
5	V	6	Maintenance		Infinity Healthcare Management of Illinois		930	930	5
6	V	10	Nursing	47,683	Infinity Healthcare Management of Illinois		14,609	(33,074)	6
7	V	11	Activities		Infinity Healthcare Management of Illinois		2,437	2,437	7
8	V	19	Professional Fees	264,747	Infinity Healthcare Management of Illinois		113,798	(150,949)	8
9	V	20	Dues & Fees		Infinity Healthcare Management of Illinois		269	269	9
10	V	21	Office Expense	76,746	Infinity Healthcare Management of Illinois		200,097	123,351	10
11	V	22	Employee Benefits		Infinity Healthcare Management of Illinois		44,932	44,932	11
12	V	24	Travel Expense	146	Infinity Healthcare Management of Illinois		1,351	1,205	12
13	V	26	Insurance		Infinity Healthcare Management of Illinois		317	317	13
14	Total			\$ 404,032			\$ 390,801	\$ * (13,231)	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	30	Depreciation	\$	Infinity Healthcare Management of Illinois		\$ 225	\$ 225	15
16	V	32	Interest		Infinity Healthcare Management of Illinois		2,911	2,911	16
17	V	34	Rent		Infinity Healthcare Management of Illinois		5,292	5,292	17
18	V								18
19	V	26	Insurance		Forest View Nursing Realty, LLC		27,376	27,376	19
20	V	31	Amortization		Forest View Nursing Realty, LLC		229,964	229,964	20
21	V	19	Professional Fees		Forest View Nursing Realty, LLC		11,010	11,010	21
22	V	21	Office Expense		Forest View Nursing Realty, LLC		250	250	22
23	V	30	Depreciation		Forest View Nursing Realty, LLC		173,493	173,493	23
24	V	32	Interest		Forest View Nursing Realty, LLC		185,482	185,482	24
25	V	34	Rent	1,094,513	Forest View Nursing Realty, LLC			(1,094,513)	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			\$ 1,094,513			\$ 636,003	\$ * (458,510)	39

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Niles Nursing & Rehab Center	Niles				1
2			Oak Lawn Respiratory & Rehab Center	Oak Lawn				2
3			Parker Nursing & Rehab Center	Streator				3
4			Parkshore Estates Nursing & Rehab Ctr	Chicago				4
5			Southpoint Nursing & Rehab Center	Chicago				5
6			West Suburban Nursing & Rehab Center	Bloomington				6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			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

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 Loan		X	Mortgage	\$21,777.00	6/26/14	\$ 5,089,300	\$ 4,986,918	6/1/49	3.7500	\$ 185,482	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Capital One		X	Working Capital	None	Various	Various	6,060,650	None	Various	169,762	6	
7	Infinity Funding	X		Working Capital	None	Various	Various	8,631	None	Various	242	7	
8												8	
9	TOTAL Facility Related				\$21,777.00		\$ 5,089,300	\$ 11,056,199			\$ 355,486	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 5,089,300	\$ 11,056,199			\$ 355,486	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 27,376 Line # 26

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2015 report.		\$	(79,713)	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.)		\$	70,117	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	149,830	3	
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	(85,526)	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.		\$	64,304	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	77,529	8	
		2012	63,538	9	
		2013	62,180	10	
		2014	62,431	11	
		2015	70,117	12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2015 \$
				14	PLUS APPEAL COST FROM LINE 5 \$
				15	LESS REFUND FROM LINE 6 \$
				16	AMOUNT TO USE FOR RATE CALCULATION \$

- 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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Forest View Rehab & Nrsg Ctr COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0051516

CONTACT PERSON REGARDING THIS REPORT Daniel S. Gaafar

TELEPHONE (317) 237-5500 FAX #: (317) 237-5503

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 03-17-102-040	Nursing Facility	\$ 2,346.00	\$ 2,346.00
2. 03-17-102-041	Nursing Facility	\$ 33,437.00	\$ 33,437.00
3. 03-17-102-045	Nursing Facility	\$ 34,334.00	\$ 34,334.00
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 70,117.00	\$ 70,117.00

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

A. Square Feet:

46,391

B. General Construction Type:

Exterior

Brick

Frame

Block

Number of Stories

2

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

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	Land		2013	\$ 27,060	1
2	Land		2015	405,350	2
3	TOTALS			\$ 432,410	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	144		2013		\$ 1,300,000	\$ 33,333	39	\$ 33,333		\$ 87,725
5			2015		451,940	11,588	39	11,588		16,978
6			2013		4,400,420		39			
7			2015		(451,940)					
8										
	Improvement Type**									
9	Install Metal Sheet Inside Roof			2011	1,402	36	39	36		201
10	Painting and Drywall			2011	2,559	66	39	66		367
11	Install TV Jacks in Every Room			2011	18,744	481	39	481		2,541
12	Install Sprinkler Head in Elevator Shaft			2011	1,485	38	39	38		213
13	Build & Install Exterior Sign			2011	6,435	165	39	165		922
14	Remove Old Fans and Paint Walls			2011	1,100	28	39	28		157
15										
16	Remove and Replace Fire Sprinklers			2012	9,683	248	39	248		1,241
17	Remodel Resident Bathrooms			2012	12,905	331	39	331		1,655
18	Remodel Dining Room			2012	4,085	105	39	105		524
19	New phones and wiring			2012						
20	Install new TV jacks			2012	3,750	96	39	96		480
21	Install exhaust fans in bathrooms			2012	1,950	50	39	50		250
22	Install new outlets throughout bedrooms			2012	9,980	256	39	256		1,280
23	Remodel lobby, vestibule, hallway, etc.			2012	226,000	5,795	39	5,795		28,973
24	Install fire dampers in exhaust fans			2012	40,423	1,036	39	1,036		5,181
25	Connect electricity for sign light			2012	2,043	52	39	52		261
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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 View Rehab & Nrsg Ctr

0051516

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	Painting on 1st floor resident rooms	2013	\$ 2,725	\$ 70	39	\$ 70	\$	\$ 245	37
38	Tub removal, new tiles on 1st floor	2013	650	17	39	17		59	38
39	Install cove base on 1st floor	2013	300	8	39	8		28	39
40	Water Heater	2013	3,455	89	39	89		311	40
41	Roof work due to leak	2013	2,900	74	39	74		260	41
42	Modify emergency panel for 2 phase 120/208 service & transforme	2013	9,650	247	39	247		865	42
43	Johnsite sihouette Base, light Oak Wall Art rubber wall base	2013	2,400	62	39	62		216	43
44	Plumbing, lights, cove base, paint, ceiling tiles in copy room	2013	3,100	79	39	79		277	44
45	Flooring and cove base in 5 resident rooms	2012	12,100	310	39	310		1,001	45
46	Lighting in vestibule, chrome grids for elevator, signage	2013	1,300	33	39	33		116	46
47	Waste line, electrical in ceiling and A/C work in Lobby	2013	4,000	103	39	103		360	47
48	Sprinkler work, pipe inspection, relocate sprinkler heads	2013	8,994	231	39	231		807	48
49	Pump motor and bearings in water heater boiler.	2013	2,467	63	39	63		221	49
50	Cubicle curtains	2013	1,097	28	39	28		98	50
51	Replace asphalt	2013	2,550	65	39	65		228	51
52	Open wall, replace pips on 1st floor	2013	1,500	38	39	38		134	52
53	Opened 40'x16' roof area and sealed	2013	2,379	61	39	61		214	53
54									54
55	Chicago Pro - stell exterior door	2014	13,999	359	39	359		1,077	55
56	Hinsdale Tile & Carpet - 3rd floor corridors tile	2014	4,874	125	39	125		375	56
57	Superior Construction - replace 2nd floor hallway carpet	2014			39				57
58	Cybor Fire - fire sprinklers	2014	2,891	74	39	74		222	58
59	Superior Construction - replace 2nd floor hallway carpet	2014	4,990	128	39	128		384	59
60	C.S.R. - patch cracks on main driveway	2014	2,100	54	39	54		162	60
61	Greenview Construction - replace masonry walls & doors	2014	4,217	108	39	108		324	61
62	Suburban Elevator - furnishh & instill door restrictors	2014	2,980	76	39	76		228	62
63	Valley Fire Protection - replace pipes with cast iron	2014	4,700	121	39	121		363	63
64	Valley Fire Protection - gas water heaters	2014	13,000	333	39	333		999	64
65	Precision Heating - generator room duct work	2014	2,265	58	39	58		174	65
66	Superior Construction - replace tiles & open kitchen wall	2014	4,512	116	39	116		348	66
67	Precision Heating - air louver for heating boilers	2014	3,855	99	39	99		297	67
68	Cary Supply - new wander system	2014	3,467	89	39	89		267	68
69	Replace bedroom floor tile	2014			39				69
70	TOTAL (lines 4 thru 69)		\$ 6,172,382	\$ 57,022		\$ 57,022	\$	\$ 159,609	70

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

Facility Name & ID Number Forest View Rehab & Nrsg Ctr

0051516

Report Period Beginning:

01/01/16

Ending:

12/31/16

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		\$ 6,172,382	\$ 57,022		\$ 57,022	\$	\$ 159,609	1
2	Furnish and install one standard pit ladder per elevator	2015	3,900	100	39	100		100	2
3	Inspect and clean all fire dampers in the building	2015	2,758	71	39	71		142	3
4	Apply patches to the north and south sections of the roof	2015			39				4
5	Paint rooms 134,137,147,149,150,152,237 & conf. rm	2015	3,250	83	39	83		166	5
6	Repair and repave parking lot	2015	39,000	1,000	39	1,000		2,000	6
7	Repair south canopy ceiling, brick, and metal drip edge	2015	3,950	101	39	101		202	7
8	Repair or replace damaged shingles	2015	3,950	101	39	101		202	8
9	Apply patch to the field/wall flashings (North & South sect.)	2015	6,021	155	39	155		310	9
10	Renovate 2nd Flr - Replace floor, cove base, chair rail, and								10
11	wallcoverings in dining room. Paint doors/windows and add								11
12	furnishings in dining room. Replace floor, cove base,								12
13	handrails, ceiling lighting, wallpaper, and signage in hallway.								13
14	Paint doors/windows and add furnishings in hallway.	2015	140,347	3,598	39	3,598		7,196	14
15	Install new circuit breaker system	2015	14,100	362	39	362		724	15
16									16
17	Install dedicated generator line 2nd floor	2016	1,375	35	39	35		35	17
18	Replace therapy room windows	2016	5,000	128	39	128		128	18
19	Paint kitchen, therapy room, & day room	2016	2,550	65	39	65		65	19
20	Stain railings on entire 2nd floor	2016	1,980	51	39	51		51	20
21	Replace fire alarm system hardware	2016	5,900	151	39	151		151	21
22	Doors for 1st floor main entrance, 2nd floor N exit and hallway	2016	4,374	112	39	112		112	22
23	New facility surveillance cameras	2016	5,000	128	39	128		128	23
24	DISPOSAL - Pit ladders from FY 15	2016	(3,900)	(100)	39	(100)		(100)	24
25	DISPOSAL - Roof repair (repair south canopy ceiling) from FY 15	2016	(3,950)	(101)	39	(101)		(101)	25
26	IDPH Capital Report Adjustments 6/30/16	2016	(170,898)						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,237,089	\$ 63,062		\$ 63,062	\$	\$ 171,120	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	\$1,118,624	\$195,652	\$223,725	\$28,073	5-7	\$1,024,177	71
72	Current Year Purchases	54,747	10,949	10,949		5	10,949	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,173,371	\$206,601	\$234,674	\$28,073		\$1,035,126	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$7,842,870	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$269,663	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$297,736	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$28,073	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,206,246	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: N/A
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:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$
- Description:
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

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

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$	3,884	\$ 290,805	\$	3,884	\$ 290,805	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,296	111,274		1,296	111,274	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		5,995	367,637		5,995	367,637	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				99,363		99,363	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): <u>X-Ray & Lab</u>	39-2					7,714		7,714	12
13	Other (specify): <u></u>									13
14	TOTAL			\$	11,175	\$ 769,716	\$ 107,077	11,175	\$ 876,793	14

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (125,476)	\$ 372,675	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,924,670	2,924,670	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	138,715	138,715	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Escrow Accounts</u>		43,172	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,937,909	\$ 3,479,232	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		505,350	13
14	Buildings, at Historical Cost		1,751,940	14
15	Leasehold Improvements, at Historical Cost	707,565	707,565	15
16	Equipment, at Historical Cost	273,371	1,173,371	16
17	Accumulated Depreciation (book methods)	(297,970)	(1,206,246)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	113,171	3,562,624	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(845,371)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): <u>Replacement Res</u>	25,584	493,470	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 821,721	\$ 6,142,703	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,759,630	\$ 9,621,935	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,185,221	\$ 1,257,048	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,199	8,199	28
29	Short-Term Notes Payable		104,073	29
30	Accrued Salaries Payable	193,817	193,817	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,271	21,271	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		15,348	33
34	Deferred Compensation	549	549	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Working Capital</u>	6,060,650	6,060,650	36
37	<u>Working Capital</u>	7,651	7,651	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,477,358	\$ 7,668,606	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		4,832,819	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)	\$	\$ 4,832,819	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,477,358	\$ 12,501,425	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,717,728)	\$ (2,879,490)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,759,630	\$ 9,621,935	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,060,030)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,060,030)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	340,931	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) Prior Year Correction	1,371	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 342,302	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)	\$ (3,717,728)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Forest View Rehab & Nrsg Ctr

0051516

Report Period Beginning: 01/01/16

Ending: 12/31/16

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	\$ 7,931,608	1
2	Discounts and Allowances for all Levels	440,684	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,372,292	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	647,154	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 647,154	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	61,589	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,683	19
20	Radiology and X-Ray	556	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 68,828	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	856	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 856	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Misc Income	1,593	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,593	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,090,723	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,089,812	31
32	Health Care	4,141,969	32
33	General Administration	1,526,713	33
	B. Capital Expense		
34	Ownership	1,421,855	34
	C. Ancillary Expense		
35	Special Cost Centers	108,832	35
36	Provider Participation Fee	266,929	36
	D. Other Expenses (specify):		
37	<u>Bad Debt Expense</u>	193,682	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,749,792	40
41	Income before Income Taxes (line 30 minus line 40)**	340,931	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 340,931	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 5,591,828	44
45	Private Pay - Net Inpatient Revenue	493,945	45
46	Medicare - Net Inpatient Revenue	1,409,235	46
47	Other-(specify)	877,284	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,372,292	49

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

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

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,830	2,090	\$ 97,626	\$ 46.71	1
2	Assistant Director of Nursing	3,998	4,661	164,182	35.22	2
3	Registered Nurses	20,073	22,099	693,913	31.40	3
4	Licensed Practical Nurses	16,671	18,097	483,919	26.74	4
5	CNAs & Orderlies	68,452	75,045	1,071,147	14.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	8,416	8,946	126,761	14.17	9
10	Activity Assistants					10
11	Social Service Workers	2,541	2,731	61,561	22.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,622	17,002	223,092	13.12	15
16	Dishwashers					16
17	Maintenance Workers	1,956	2,130	32,158	15.10	17
18	Housekeepers	14,032	14,940	188,403	12.61	18
19	Laundry	153	153	1,590	10.39	19
20	Administrator	2,003	2,105	104,319	49.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,142	17,845	276,944	15.52	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,090	2,143	33,220	15.50	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	173,979	189,987	\$ 3,558,835 *	\$ 18.73	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	420	\$ 14,710	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	1,362	47,683	10-3	38
39	Pharmacist Consultant	205	10,251	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	4,060	203,013	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	466	16,317	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	6,513	\$ 291,974		49

C. CONTRACT NURSES

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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

Forest View Rehab & Nrsg Ctr

#

0051516

Report Period Beginning:

01/01/16

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Ending:

12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Margaux Dominguez	Administrator		\$ 25,713	Workers' Compensation Insurance	\$ 51,640	IDPH License Fee	\$	
John Marc Sianghio	Administrator		78,606	Unemployment Compensation Insurance	60,701	Advertising: Employee Recruitment		
				FICA Taxes	278,501	Health Care Worker Background Check		
				Employee Health Insurance	206,904	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		IHCA	5,212	
				Pension	42,388	Dupage County Health Dept	1,000	
				Employee Exp	24,397	Village of Itasca	435	
						Other Dues & Fees	572	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 104,319					
B. Administrative - Other								
Description			Amount					
			\$			Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
				TOTAL (agree to Schedule V,	\$ 664,531	TOTAL (agree to Sch. V,	\$ 7,219	
				line 22, col.8)		line 20, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				to Owners or Employees				
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type	Amount				\$	Out-of-State Travel	\$
Bradley Associates	Accounting	\$ 8,627						
Johnson, Goldburg	Accounting	2,900						
Capital One	Accounting	3,778						
Johnson & Bell	Legal	51,152					In-State Travel	
Dutton & Casey	Legal	2,000					Mileage	319
Infinity Healthcare	Prof/Mgmt Fees	311,929						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				
(For legal fee disclosure, see page 39 of instructions)			\$ 380,386			\$	Entertainment Expense	()
							(agree to Sch. V,	
							line 24, col. 8)	\$ 3,289

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number Forest View Rehab & Nrsg Ctr	STATE OF ILLINOIS # 0051516	Report Period Beginning: 01/01/16	Ending: 12/31/16	Page 22
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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. Illinois Council - \$5,514

(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? N/A

(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? 5 Yesars

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 63,897 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. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 266,929
 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? Np 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 benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A

(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. \$ N/A
 c. What percent of all travel expense relates to transportation of nurses and patients? 0%
 d. Have vehicle usage logs been maintained? N/A
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
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: N/A

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
 Attach invoices and a summary of services for all architect and appraisal fees