

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: <u>0052803</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Forest City Rehab Nrsg Ctr</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2020</u> to <u>12/31/2020</u> 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.	
Address: <u>321 Arnold Avenue</u> <u>Rockford</u> <u>61108</u>			
Number City Zip Code			
County: <u>Winnebago</u>			
Telephone Number: <u>(815)397-5531</u> Fax # <u>(815)397-7629</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>06/01/2014</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ CORPORATION	
		☐ "Sub-S" Corp.	
		☒ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Mendel Schneider</u>		Telephone Number: <u>(847)933-1274</u>	
		Email Address: _____	
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) _____	
		(Title) _____	
		(Signed) _____ (Date) _____	
		Paid Preparer	
		(Print Name and Title) <u>See Accountant's Report Attached</u>	
		(Firm Name & Address) <u>Mendel S Schneider C.P.A & Associates</u> <u>4051 Old Orchard Rd, Skokie, IL 60076</u>	
		(Telephone) <u>(847)933-1274</u> Fax # <u>(847)933-1283</u>	
		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 City Rehab Nrsg Ctr

0052803 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>99</u>	Skilled (SNF)	<u>99</u>	<u>36,234</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>114</u>	Intermediate (ICF)	<u>114</u>	<u>41,724</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>213</u>	TOTALS	<u>213</u>	<u>77,958</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>16,265</u>	<u>379</u>	<u>4,107</u>	<u>20,751</u>	8
9	SNF/PED					9
10	ICF	<u>41,724</u>			<u>41,724</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>57,989</u>	<u>379</u>	<u>4,107</u>	<u>62,475</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.14%

D. How many bed reserve days during this year were paid by the Department?

None (Do not include bed reserve 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

08/24/2017

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

YES

X

Date

08/24/2017

NO

☐

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

YES

X

NO

☐

If YES, enter number

of beds certified

99

and days of care provided

4,095

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

X

NO

☐

Tax Year:

12/31

Fiscal Year:

12/31

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

Facility Name & ID Number Forest City Rehab Nrsg Ctr # 0052803 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	334,199	47,585	11,280	393,064		393,064		393,064			1
2	Food Purchase		357,420		357,420		357,420	(438)	356,982			2
3	Housekeeping	282,990	29,180	36,698	348,868		348,868		348,868			3
4	Laundry	88,432	14,179		102,611		102,611		102,611			4
5	Heat and Other Utilities			150,599	150,599		150,599		150,599			5
6	Maintenance	80,298		47,419	127,717		127,717	223	127,940			6
7	Other (specify):*											7
8	TOTAL General Services	785,919	448,364	245,996	1,480,279		1,480,279	(215)	1,480,064			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,494,090	201,267	207,873	2,903,230		2,903,230	(81,115)	2,822,115			10
10a	Therapy											10a
11	Activities	133,028	6,236		139,264		139,264		139,264			11
12	Social Services	234,594		3,003	237,597		237,597		237,597			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Allocated Benifets							8,911	8,911			15
16	TOTAL Health Care and Programs	2,861,712	207,503	222,876	3,292,091		3,292,091	(72,204)	3,219,887			16
	C. General Administration											
17	Administrative	120,756		657,207	777,963		777,963	(558,413)	219,550			17
18	Directors Fees											18
19	Professional Services			32,022	32,022		32,022	19,815	51,837			19
20	Dues, Fees, Subscriptions & Promotions			52,024	52,024		52,024	(2,616)	49,408			20
21	Clerical & General Office Expenses	259,638	57,266	193,217	510,121		510,121	144,807	654,928			21
22	Employee Benefits & Payroll Taxes			486,593	486,593		486,593		486,593			22
23	Inservice Training & Education											23
24	Travel and Seminar			166	166		166		166			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			321,124	321,124		321,124		321,124			26
27	Other (specify):* Allocated Benifets							31,732	31,732			27
28	TOTAL General Administration	380,394	57,266	1,742,353	2,180,013		2,180,013	(364,675)	1,815,338			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,028,025	713,133	2,211,225	6,952,383		6,952,383	(437,094)	6,515,289			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			19,599	19,599		19,599	599,731	619,330			30
31	Amortization of Pre-Op. & Org.			5,779	5,779		5,779	56,386	62,165			31
32	Interest							1,116,202	1,116,202			32
33	Real Estate Taxes							172,075	172,075			33
34	Rent-Facility & Grounds			1,652,721	1,652,721		1,652,721	(1,638,023)	14,698			34
35	Rent-Equipment & Vehicles			293	293		293		293			35
36	Other (specify):*											36
37	TOTAL Ownership			1,678,392	1,678,392		1,678,392	306,371	1,984,763			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		101,859	408,077	509,936		509,936		509,936			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			478,741	478,741		478,741		478,741			42
43	Other (specify):* Bad Debt Expense			88,270	88,270		88,270	(88,270)				43
44	TOTAL Special Cost Centers		101,859	975,088	1,076,947		1,076,947	(88,270)	988,677			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,028,025	814,992	4,864,705	9,707,722		9,707,722	(218,993)	9,488,729			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	(199,895)	30		9
10	Interest and Other Investment Income	(847)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(438)	2		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	(50,000)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(88,270)	43		24
25	Fund Raising, Advertising and Promotional	(2,686)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(35,794)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (377,930)		\$	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)	158,937		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 158,937		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (218,993)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Forest City Rehab Nrsg Ctr# 0052803

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(438)	0	0	0	0	0	0	0	0	0	0	(438)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	223	0	0	0	0	0	0	0	0	223	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(438)	0	223	0	0	0	0	0	0	0	0	(215)	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	(81,115)	0	0	0	0	0	0	0	0	(81,115)	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	8,911	0	0	0	0	0	0	0	0	8,911	15
16	TOTAL Health Care and Programs	0	0	(72,204)	0	0	0	0	0	0	0	0	(72,204)	16
	C. General Administration													
17	Administrative	0	0	(558,413)	0	0	0	0	0	0	0	0	(558,413)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	675	19,140	0	0	0	0	0	0	0	0	19,815	19
20	Fees, Subscriptions & Promotions	(2,686)	0	70	0	0	0	0	0	0	0	0	(2,616)	20
21	Clerical & General Office Expenses	(85,794)	2,183	228,418	0	0	0	0	0	0	0	0	144,807	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	31,732	0	0	0	0	0	0	0	0	31,732	27
28	TOTAL General Administration	(88,480)	2,858	(279,053)	0	0	0	0	0	0	0	0	(364,675)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(88,918)	2,858	(351,034)	0	0	0	0	0	0	0	0	(437,094)	29

Summary B

12/31/2020

[illegible]

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
See supplemental schedule		See supplemental schedule		See supplemental schedule		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 1,652,721	Forest City Nursing & Rehab Center Realty, LLC	100.00%	\$	(1,652,721)	1
2	V	32	Interest expense		Forest City Nursing & Rehab Center Realty, LLC	100.00%	1,117,049	1,117,049	2
3	V	19	Professional fees		Forest City Nursing & Rehab Center Realty, LLC	100.00%	675	675	3
4	V	33	Real Estate Taxes		Forest City Nursing & Rehab Center Realty, LLC	100.00%	172,075	172,075	4
5	V	30	Depreciation		Forest City Nursing & Rehab Center Realty, LLC	100.00%	799,626	799,626	5
6	V	31	Amortization		Forest City Nursing & Rehab Center Realty, LLC	100.00%	56,386	56,386	6
7	V	21	Office		Forest City Nursing & Rehab Center Realty, LLC	100.00%	2,183	2,183	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,652,721			\$ 2,147,994	\$ * 495,273	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	21	Clerical Salaries	\$	SABA HEALTHCARE		\$ 194,555	\$ 194,555	15
16	V	27	Payroll Taxes		SABA HEALTHCARE		13,294	13,294	16
17	V	27	Employee Benifets		SABA HEALTHCARE		18,438	18,438	17
18	V	10	Nursing salary		SABA HEALTHCARE		116,482	116,482	18
19	V	20	Dues & Subs		SABA HEALTHCARE		70	70	19
20	V	19	Professional Fees		SABA HEALTHCARE		19,140	19,140	20
21	V	34	Rent		SABA HEALTHCARE		14,698	14,698	21
22	V	6	Repairs & Maintenance		SABA HEALTHCARE		223	223	22
23	V	21	Telephone		SABA HEALTHCARE		1,558	1,558	23
24	V	17	Salary Blonder		SABA HEALTHCARE		49,397	49,397	24
25	V	17	Salary Singer		SABA HEALTHCARE		49,397	49,397	25
26	V	21	Admin & General Expenses		SABA HEALTHCARE		32,305	32,305	26
27	V	15	Nursing Benifets		SABA HEALTHCARE		8,911	8,911	27
28	V								28
29	V	17	Management Fees	657,207	SABA HEALTHCARE			(657,207)	29
30	V	10	Nurse Consultant	197,597	SABA HEALTHCARE			(197,597)	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			\$ 854,804			\$ 518,468	\$ * (336,336)	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	Shimon Webster	9.68	Arista Healthcare	Naperville	Saba Healthcare	Skokie	Management	1
2	Yeruchom Levovitz	8.28	Parc joliet Nursing	Joliet	Saba Financial	Skokie	Management	2
3	Jeffrey Webster	3.12	Rock River Healthcare	Rockford	Fosest City Realty	Rockford	Building Rental	3
4	Eli Webster	.94	Pearl Pavillion	Freeport				4
5	EZ&A LLC	.93	Briar Place Nursing	Indian Head Park				5
6	Howard Wengrow	2.35	Spring Creek SNF	Joliet				6
7	Moshe Levovitz	.94	Center Home Hispanic Elderly	Chicago				7
8	Kevin Chankin	2.35	Pine Crest Health Care	Hazel crest				8
9	Yehuda orlansky	.47	Park View Rehab center	Chicago				9
10	Aaron Singer	22	River View Rehab center	Elgin				10
11	Moshe Blonder	22	Prairie Oasis	South Holland				11
12	Atied Associates,LLC	24	Oak park Oasis	Oak Park				12
13	Yaakov ribowsky	.47	Austin Oasis	Chicago				13
14	Rivky Kaminsky	.47						14
15	BBF Investments LP	2.00						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	Aaron Singer	Owner	Administrative	33.34	200,603	6.66	16.67	Mgmt Fee	\$ 49,397	17-7	1
2	Moshe Blonder	Owner	Administrative	33.33	200,603	6.66	16.67	Mgmt Fee	49,397	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 98,794		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 City Rehab Nrsng Ctr# 0052803 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

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

SABA HEALTHCARE

Street Address

3515 w Howard

City / State / Zip Code

Skokie, IL 60076

Phone Number

(847)383-9104

Fax Number

()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Clerical Salaries	Number of Beds	1,078	6	\$ 984,647	\$ 984,647	213	\$ 194,555	1
2	27	Payroll Taxes	Number of Beds	1,078	6	67,280		213	13,294	2
3	27	Employee Benifets	Number of Beds	1,078	6	93,316		213	18,438	3
4	10	Nursing salary	Number of Beds	1,078	6	589,519	589,519	213	116,482	4
5	20	Dues & Subs	Number of Beds	1,078	6	356		213	70	5
6	19	Professional Fees	Number of Beds	1,078	6	96,869		213	19,140	6
7	34	Rent	Number of Beds	1,078	6	74,385		213	14,698	7
8	6	Repairs & Maintenance	Number of Beds	1,078	6	1,130		213	223	8
9	21	Telephone	Number of Beds	1,078	6	7,884		213	1,558	9
10	17	Salary Blonder	Number of Beds	1,078	6	250,000	250,000	213	49,397	10
11	17	Salary Singer	Number of Beds	1,078	6	250,000	250,000	213	49,397	11
12	21	Admin & General Expenses	Number of Beds	1,078	6	163,497		213	32,305	12
13	15	Nursing Benifets	Number of Beds	1,078	6	45,098		213	8,911	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					\$ 2,623,981	\$ 2,074,166		\$ 518,468	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	Fifth Third Bank		X	Mortgage			\$ 15,500,000	\$ 15,500,000			\$ 1,117,049	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 15,500,000	\$ 15,500,000			\$ 1,117,049	9	
	B. Non-Facility Related*												
10	Interst Income										(847)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (847)	14	
15	TOTALS (line 9+line14)						\$ 15,500,000	\$ 15,500,000			\$ 1,116,202	15	

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2019 report.				\$	81,292	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.)				\$	126,355	2
3. Under or (over) accrual (line 2 minus line 1).				\$	45,063	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	127,012	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.				\$	172,075	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2015	126,540	8		
		2016	124,964	9		
		2017	125,079	10		
		2018	125,706	11		
		2019	126,355	12		
accrual- 126355.26 x 1.0052						

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	\$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Forest City Rehab Nrsg Ctr COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0052803

CONTACT PERSON REGARDING THIS REPORT Mendel Schneider

TELEPHONE (847)933-1274 FAX #: (847)933-1283

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. 12-28-203-004	Nursing Home	\$ 126,355.26	\$ 126,355.26
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 126,355.26	\$ 126,355.26

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 58,808

B. General Construction Type: Exterior Brick Frame

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).

None

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: 127,500 19813 240,737

2. Number of Years Over Which it is Being Amortized: 5

3. Current Period Amortization: 62,165

4. Dates Incurred: 8/24/17 3/31/20

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	Facility		2017	\$ 2,407,090	1
2					2
3	TOTALS			\$ 2,407,090	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	213		2017	1977	\$ 13,405,346	\$	39	\$ 343,729	\$ 343,729	\$ 1,374,910	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2014		92,334		20	4,617	4,617	25,677	9
10	Elevators-New cylinders ,Pistons, Protective Coverings,Oil Line		2015		24,500		20	1,225	1,225	7,963	10
11	Bathroom/Therapy Piping,Door,Framing,Plumbing repair		2015		6,780		20	339	339	1,977	11
12	Water heater with new 20 gallon Holding Tank		2015		21,657		20	1,083	1,083	5,505	12
13	Compressor replacer on freezer		2017		3,116		20	156	156	883	13
14	Dumpster Enclosure/Fencing with gates, Steel frames,, 4 inch Post		2017		5,500		20	275	275	1,131	14
15	Replaced heat Exchanger, Collector Box, and Inducer Fan for heat		2017		2,592		20	130	130	520	15
16	Replacement of 100 Gallon Water Heater with piping		2018		7,700		20	385	385	1,155	16
17	Replaced Jetter hose and drain pipe for kitchen		2018		12,000		20	600	600	1,800	17
18	Piping/backflow prevento/valve for cold water entering building		2018		7,000		20	350	350	1,050	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	Financial Statement Depreciation					819,225			(819,225)		32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$13,588,525	\$819,225		\$352,889	\$(466,336)	\$1,422,571	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$2,653,036	\$	\$265,304	\$265,304	10	\$1,090,322	71
72	Current Year Purchases	11,369		1,137	1,137	10	1,137	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$2,664,405	\$	\$266,441	\$266,441		\$1,091,459	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)				\$18,660,020	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)				\$819,225	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)				\$619,330	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)				\$(199,895)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)				\$2,514,030	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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated from Saba				14,698			5
6								6
7	TOTAL				\$ 14,698			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: \$ 293
- Description: Medical Equipment Rental
- (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.

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.	/2021	\$
13.	/2022	\$
14.	/2023	\$

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

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)	\$			

(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.

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	

(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	39-3	hrs	\$		\$ 142,456	\$		\$ 142,456	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			98,999			98,999	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			166,622			166,622	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				91,897		91,897	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & Xray	39-2					9,962		9,962	12
13	Other (specify):									13
14	TOTAL			\$		\$ 408,077	\$ 101,859		\$ 509,936	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,434,609	\$ 4,376,715	1
2	Cash-Patient Deposits	191,467	191,467	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,729,566	1,729,566	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	103,049	103,049	6
7	Other Prepaid Expenses	97,483	97,483	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from related Party, escrows	4,310	302,979	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,560,484	\$ 6,801,259	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		2,407,090	13
14	Buildings, at Historical Cost		10,283,472	14
15	Leasehold Improvements, at Historical Cost	171,285	587,306	15
16	Equipment, at Historical Cost	40,622	2,972,633	16
17	Accumulated Depreciation (book methods)	(117,994)	(2,343,768)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	19,813	183,313	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(5,779)	(99,904)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 107,947	\$ 13,990,142	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,668,431	\$ 20,791,401	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 305,497	\$ 305,623	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	191,467	191,467	28
29	Short-Term Notes Payable	1,124,210	1,124,210	29
30	Accrued Salaries Payable	229,714	229,714	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,914	4,914	31
32	Accrued Real Estate Taxes(Sch.IX-B)		127,012	32
33	Accrued Interest Payable		53,389	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	189,253	189,253	35
	Other Current Liabilities(specify):			
36	Deferred Provider Relief Funds	1,524,385	1,524,385	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,569,440	\$ 3,749,967	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		15,319,149	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)	\$	\$ 15,319,149	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,569,440	\$ 19,069,116	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,098,991	\$ 1,722,285	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,668,431	\$ 20,791,401	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,333,720	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,333,720	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,541,745	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	(1,776,474)	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)	\$ (234,729)	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)	\$ 2,098,991	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Forest City Rehab Nrsng Ctr

0052803

Report Period Beginning: 01/01/2020

Ending:

12/31/2020

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	\$ 10,922,451	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,922,451	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	847	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 847	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Government Stimulus Income</u>	326,169	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 326,169	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,249,467	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,480,279	31
32	Health Care	3,292,091	32
33	General Administration	2,180,013	33
	B. Capital Expense		
34	Ownership	1,678,392	34
	C. Ancillary Expense		
35	Special Cost Centers	598,206	35
36	Provider Participation Fee	478,741	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,707,722	40
41	Income before Income Taxes (line 30 minus line 40)**	1,541,745	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,541,745	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 8,316,134	44
45	Private Pay - Net Inpatient Revenue	72,010	45
46	Medicare - Net Inpatient Revenue	2,430,455	46
47	Other-(specify) <u>Insurance</u>	5,400	47
48	Other-(specify) <u>Med B</u>	98,452	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,922,451	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No, Cash Basis If not, please attach a reconciliation.

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

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

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	3,984	4,130	\$ 165,357	\$ 40.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,429	14,287	472,659	33.08	3
4	Licensed Practical Nurses	27,564	29,410	852,482	28.99	4
5	CNAs & Orderlies	61,653	64,512	888,258	13.77	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,537	5,104	74,630	14.62	8
9	Activity Director	2,083	2,207	37,901	17.17	9
10	Activity Assistants	7,425	7,909	95,127	12.03	10
11	Social Service Workers	13,013	14,040	234,594	16.71	11
12	Dietician					12
13	Food Service Supervisor	1,992	2,160	59,985	27.77	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,359	23,715	274,214	11.56	15
16	Dishwashers					16
17	Maintenance Workers	4,726	5,247	80,298	15.30	17
18	Housekeepers	22,306	24,019	282,990	11.78	18
19	Laundry	7,521	7,872	88,432	11.23	19
20	Administrator	2,036	2,108	120,756	57.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,683	12,440	259,638	20.87	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	2,395	2,640	40,704	15.42	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	208,706	221,800	\$ 4,028,025 *	\$ 18.16	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 11,280	1-3	35
36	Medical Director	Monthly	12,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	197,597	10-3	38
39	Pharmacist Consultant	Monthly	10,276	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	60	3,003	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	60	\$ 234,156		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

STATE OF ILLINOIS

0052803

Report Period Beginning:

01/01/2020

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Ending: 12/31/2020

Facility Name & ID Number

Forest City Rehab Nrsg Ctr

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Anthony Valentino	Administrative		\$ 120,756
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 120,756

B. Administrative - Other

Description	Amount
Saba Healthcare	\$ 657,207
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 657,207

C. Professional Services

Vendor/Payee	Type	Amount
Mendel Schneider	Accounting	\$ 9,500
Marcum	Accounting	9,000
Personnel Planners	Ui Tax Consultants	1,850
Meyr Magence	Legal	6,155
Mccabe Kirschner	Legal	4,375
Vcorp	Incorp	224
Gulko Schwed	Legal	488
Holly Turner	Legal	350
Gutnicki LLP	Legal	80
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 32,022

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 73,054
Unemployment Compensation Insurance	17,670
FICA Taxes	303,112
Employee Health Insurance	92,757
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	\$ 486,593

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	\$ 1,990
Advertising: Employee Recruitment	1,950
Health Care Worker Background Check (Indicate # of checks performed)	1,725
Patient Background Checks	3,245
Advertising	2,686
Health Care Council Of Illinois	35,453
Misc License	7,474
Less: Public Relations Expense	()
Non-allowable advertising	(2,686)
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 51,837

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	166
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 166

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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. Health Care Council of Illinois 35,453

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 35,168 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 478,741
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. \$ 0 Has any meal income been offset against related costs? No 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? 100
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. \$ 0

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

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