

Facility Name & ID Number Forest View Rehab & Nrsng Ctr

0051516 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 n/a

	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	76	Skilled (SNF)	76	27,740	1
2		Skilled Pediatric (SNF/PED)			2
3	68	Intermediate (ICF)	68	24,820	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	144	TOTALS	144	52,560	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	26,233	1,773	5,796	33,802	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,233	1,773	5,796	33,802	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.31%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

none

F. Does the facility maintain a daily midnight census?

yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 06/01/2011

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

YES Date _____ 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 3,918

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number

Forest View Rehab & Nrsg Ctr

0051516

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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	190,730			190,730		190,730	10,209	200,939		1
2	Food Purchase		219,171		219,171		219,171		219,171		2
3	Housekeeping	138,095	24,296		162,391		162,391		162,391		3
4	Laundry		16,890		16,890		16,890		16,890		4
5	Heat and Other Utilities			220,901	220,901		220,901	844	221,745		5
6	Maintenance	65,589	56,265	56,850	178,704		178,704	1,846	180,550		6
7	Other (specify):*										7
8	TOTAL General Services	394,414	316,622	277,751	988,787		988,787	12,899	1,001,686		8
	B. Health Care and Programs										
9	Medical Director			15,100	15,100		15,100		15,100		9
10	Nursing and Medical Records	2,126,312	246,898	32,955	2,406,165		2,406,165	24,321	2,430,486		10
10a	Therapy			580,789	580,789		580,789		580,789		10a
11	Activities	89,835	14,131		103,966		103,966		103,966		11
12	Social Services	49,140		2,100	51,240		51,240		51,240		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* rx consultant			10,071	10,071		10,071		10,071		15
16	TOTAL Health Care and Programs	2,265,287	261,029	641,015	3,167,331		3,167,331	24,321	3,191,652		16
	C. General Administration										
17	Administrative	81,897			81,897		81,897		81,897		17
18	Directors Fees										18
19	Professional Services			402,736	402,736		402,736	(236,707)	166,029		19
20	Dues, Fees, Subscriptions & Promotions			13,199	13,199		13,199		13,199		20
21	Clerical & General Office Expenses	167,871	61,060	29,679	258,610		258,610	96,510	355,120		21
22	Employee Benefits & Payroll Taxes			599,372	599,372		599,372	25,827	625,199		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,005	3,005		3,005	294	3,299		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			142,932	142,932		142,932	842	143,774		26
27	Other (specify):*										27
28	TOTAL General Administration	249,768	61,060	1,190,923	1,501,751		1,501,751	(113,234)	1,388,517		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,909,469	638,711	2,109,689	5,657,869		5,657,869	(76,014)	5,581,855		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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			133,791	133,791		133,791	128,801	262,592			30
31	Amortization of Pre-Op. & Org.			347,117	347,117		347,117		347,117			31
32	Interest			988,679	988,679		988,679		988,679			32
33	Real Estate Taxes			67,423	67,423		67,423		67,423			33
34	Rent-Facility & Grounds			1,353,356	1,353,356		1,353,356	(1,340,118)	13,238			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			2,890,366	2,890,366		2,890,366	(1,211,317)	1,679,049			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		188,451		188,451		188,451		188,451			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			262,750	262,750		262,750		262,750			42
43	Other (specify):* bad debt expense			547,163	547,163		547,163	(547,163)				43
44	TOTAL Special Cost Centers		188,451	809,913	998,364		998,364	(547,163)	451,201			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,909,469	827,162	5,809,968	9,546,599		9,546,599	(1,834,494)	7,712,105			45

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

Facility Name & ID Number Forest View Rehab & Nrsg Ctr

0051516

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	128,801	30		9
10	Interest and Other Investment Income	(367)	21		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(547,163)	43		24
25	Fund Raising, Advertising and Promotional	(15,086)	21		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,354,642)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,788,457)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(46,037)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (46,037)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,834,494)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Forest View Rehab & Nrsg Ctr

ID# 0051516

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	misc income	\$ (1,286)	21	1
2	rent	(1,353,356)	34	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	(1,354,642)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Forest View Rehab & Nrsg Ctr# 0051516

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	10,209	0	0	0	0	0	0	0	0	0	10,209	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	844	0	0	0	0	0	0	0	0	0	844	5
6	Maintenance	0	1,846	0	0	0	0	0	0	0	0	0	1,846	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	12,899	0	0	0	0	0	0	0	0	0	12,899	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	24,321	0	0	0	0	0	0	0	0	0	24,321	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	24,321	0	0	0	0	0	0	0	0	0	24,321	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	(236,707)	0	0	0	0	0	0	0	0	0	(236,707)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(16,739)	113,249	0	0	0	0	0	0	0	0	0	96,510	21
22	Employee Benefits & Payroll Taxes	0	25,827	0	0	0	0	0	0	0	0	0	25,827	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	294	0	0	0	0	0	0	0	0	0	294	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	842	0	0	0	0	0	0	0	0	0	842	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(16,739)	(96,495)	0	0	0	0	0	0	0	0	0	(113,234)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(16,739)	(59,275)	0	0	0	0	0	0	0	0	0	(76,014)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Forest View Rehab & Nrsrg Ctr# 0051516

Report Period Beginning:

01/01/2014 Ending:12/31/2014

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	128,801	0	0	0	0	0	0	0	0	0	0	128,801	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(1,353,356)	13,238	0	0	0	0	0	0	0	0	0	(1,340,118)	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	(1,224,555)	13,238	0	(1,211,317)	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):*	(547,163)	0	0	0	0	0	0	0	0	0	0	(547,163)	43
44	TOTAL Special Cost Centers	(547,163)	0	0	0	0	0	0	0	0	0	0	(547,163)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,788,457)	(46,037)	0	(1,834,494)	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	30%			Infinity	Hillside	Mgmt Co
Moishe Gubin	30%					
Dave Schechter	30%					
Rosie Schwartz	10%					

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	6 maintenance	\$	Infinity Healthcare Management OF Illinois		\$ 1,846	\$ 1,846	1
2	V	10 nursing	23,640	Infinity Healthcare Management OF Illinois		47,961	24,321	2
3	V	1 dietary		Infinity Healthcare Management OF Illinois		10,209	10,209	3
4	V	5 utilities		Infinity Healthcare Management OF Illinois		844	844	4
5	V	21 office expense	54,434	Infinity Healthcare Management OF Illinois		167,683	113,249	5
6	V	2 food		Infinity Healthcare Management OF Illinois				6
7	V	19 prof fees	242,048	Infinity Healthcare Management OF Illinois		5,341	(236,707)	7
8	V	22 employee expenses	2,309	Infinity Healthcare Management OF Illinois		28,136	25,827	8
9	V	24 travel	297	Infinity Healthcare Management OF Illinois		591	294	9
10	V	26 insurance		Infinity Healthcare Management OF Illinois		842	842	10
11	V	34 rent		Infinity Healthcare Management OF Illinois		13,238	13,238	11
12	V	30 depreciation		Infinity Healthcare Management OF Illinois				12
13	V	32 interest		Infinity Healthcare Management OF Illinois				13
14	Total		\$ 322,728			\$ 276,691	\$ * (46,037)	14

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

Facility Name & ID Number

Forest View Rehab & Nrsg Ctr

0051516

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								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

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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: 01/01/2014

Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Forest View Rehab & Nrsrg Ctr

0051516

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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		x	mortgage	\$21,777.00	6/26/14	\$ 5,089,300	\$ 5,059,749	7/2/49	3.1250	\$ 338,055					
2																
3																
4																
5																
Working Capital																
6	capital one		x	working capital	none	various	various	840,687	none	various	264,108					
7	infinity funding	x		working capital	none	various	various	4,940,000	none	various	386,517					
8																
9	TOTAL Facility Related				\$21,777.00		\$ 5,089,300	\$ 10,840,436			\$ 988,680					
B. Non-Facility Related*																
10																
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$					
15	TOTALS (line 9+line14)						\$ 5,089,300	\$ 10,840,436			\$ 988,680					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ n/a 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 2013 report.		\$	(86,635)		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.)		\$	62,180		2										
3. Under or (over) accrual (line 2 minus line 1).		\$	148,815		3										
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	(81,392)		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.		\$	67,423		7										
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2009	_____	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$ _____</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ _____</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$ _____	14	PLUS APPEAL COST FROM LINE 5 \$ _____	15	LESS REFUND FROM LINE 6 \$ _____	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____
FOR BHF USE ONLY															
13	FROM R. E. TAX STATEMENT FOR 2013 \$ _____														
14	PLUS APPEAL COST FROM LINE 5 \$ _____														
15	LESS REFUND FROM LINE 6 \$ _____														
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____														
	2010	69,593	9												
	2011	77,529	10												
	2012	63,538	11												
	2013	62,180	12												

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.

2013 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 Alan Sorscher

TELEPHONE 708-449-1900 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 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 2013.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>03-17-102-040</u>	<u>nursing facility</u>	\$ <u>2,358.00</u>	\$ <u>2,358.00</u>
2. <u>03-17-102-041</u>	<u>nursing facility</u>	\$ <u>29,460.00</u>	\$ <u>29,460.00</u>
3. <u>03-17-102-045</u>	<u>nursing facility</u>	\$ <u>30,362.00</u>	\$ <u>30,362.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>62,180.00</u></u>	\$ <u><u>62,180.00</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 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	<u>land</u>		<u>6/1/2011</u>	<u>\$ 100,000</u>	1
2					2
3	TOTALS			\$ 100,000	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	\$	\$ 38,889	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Install Metal Sheet Inside Roof	2011		1,402	36	39	36		129	9
10	Painting and Drywall	2011		2,559	66	39	66		235	10
11	Install TV Jacks in Every Room	2011		9,200	236	39	236		846	11
12	Install Sprinkler Head in Elevator Shaft	2011		1,485	38	39	38		137	12
13	Build & Install Exterior Sign	2011		6,435	165	39	165		592	13
14	Remove Old Fans and Paint Walls	2011		1,100	28	39	28		101	14
15										15
16	Remove and Replace Fire Sprinklers	2012		9,683	248	39	248		745	16
17	Remodel Resident Bathrooms	2012		12,905	331	39	331		993	17
18	Remodel Dining Room	2012		4,085	105	39	105		314	18
19	New phones and wiring	2012		9,544	245	39	245		734	19
20	Install new TV jacks	2012		3,750	96	39	96		288	20
21	Install exhaust fans in bathrooms	2012		1,950	50	39	50		150	21
22	Install new outlets throughout bedrooms	2012		9,980	256	39	256		768	22
23	Remodel lobby, vestibule, hallway, etc.	2012		226,000	5,795	39	5,795		17,384	23
24	Install fire dampers in exhaust fans	2012		40,423	1,036	39	1,036		3,109	24
25	Connect electricity for sign light	2012		2,043	52	39	52		157	25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Forest View Rehab & Nrsg Ctr

0051516

Report Period Beginning:

01/01/2014 Ending:

12/31/2014

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Claudiu Stoica	2/15/2013	\$ 2,725	\$ 70	39	\$ 70	\$	\$ 105	37
38	Claudiu Stoica	1/19/2013	650	17	39	17		25	38
39	Claudiu Stoica	3/1/2013	300	8	39	8		12	39
40	HD Supply	11/18/2013	3,455	89	39	89		133	40
41	Champion Roofing	4/2/2013	2,900	74	39	74		112	41
42	Adig Construction	1/4/2013	9,650	247	39	247		371	42
43	Integra	2/20/2013	2,400	62	39	62		92	43
44	Integra	5/29/2013	3,100	79	39	79		119	44
45	Integra	12/3/2012	5,500	141	39	141		212	45
46	Integra	5/29/2013	1,300	33	39	33		50	46
47	Integra	5/29/2013	4,000	103	39	103		154	47
48	Protective Fire	3/19/2013	8,994	231	39	231		346	48
49	Precision Heating	1/18/2013	2,467	63	39	63		95	49
50	Medallion Services	11/26/2012	1,097	28	39	28		42	50
51	Qualified Landscaping	7/10/2013	2,550	65	39	65		98	51
52	Solomon Plumbing	7/9/2013	1,500	38	39	38		58	52
53	Chicago Pro	11/22/2013	2,379	61	39	61		92	53
54									54
55	Chicago Pro - stell exterior door	2014	13,999	359	39	359		359	55
56	Hinsdale Tile & Carpet - 3rd floor corridors tile	2014	4,874	125	39	125		125	56
57	Superior Construction - replace 2nd floor hallway carpet	2014	2,810	72	39	72		72	57
58	Cybor Fire - fire sprinklers	2014	2,891	74	39	74		74	58
59	Superior Construction - replace 2nd floor hallway carpet	2014	2,180	56	39	56		56	59
60	C.S.R. - patch cracks on main driveway	2014	2,100	54	39	54		54	60
61	Greenview Construction - replace masonry walls & doors	2014	4,217	108	39	108		108	61
62	Suburban Elevator - furnishh & instill door restrictors	2014	2,980	76	39	76		76	62
63	Valley Fire Protection - replace pipes with cast iron	2014	4,700	121	39	121		121	63
64	Valley Fire Protection - gas water heaters	2014	13,000	333	39	333		333	64
65	Precision Heating - generator room duct work	2014	2,265	58	39	58		58	65
66	Superior Construction - replace tiles & open kitchen wall	2014	4,512	116	39	116		116	66
67	Precision Heating - air louver for heating boilers	2014	3,855	99	39	99		99	67
68	Cary Supply - new wander system	2014	3,467	89	39	89		89	68
69	Integra	2014	6,600	169	39	169		169	69
70	TOTAL (lines 4 thru 69)		\$ 1,771,962	\$ 45,434		\$ 45,434	\$	\$ 69,596	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	\$ 1,069,856	\$ 79,619	\$ 213,971	\$ 134,352	5/7	\$ 671,475	71
72	Current Year Purchases	15,933	8,738	3,187	(5,551)	5	8,738	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,085,789	\$ 88,357	\$ 217,158	\$ 128,801		\$ 680,213	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,957,751	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 133,791	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 262,592	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 128,801	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 749,809	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

Facility Name & ID Number Forest View Rehab & Nrsg Ctr

0051516

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

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

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$		\$ 145,347	\$		\$ 145,347	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			61,207			61,207	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			374,235			374,235	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				171,408		171,408	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>lab xray amb</u>	39-2					17,043		17,043	12
13	Other (specify):									13
14	TOTAL			\$		\$ 580,789	\$ 188,451		\$ 769,240	14

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

Facility Name & ID Number Forest View Rehab & Nrsg Ctr# 0051516Report Period Beginning: 01/01/2014Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 67,280	\$ 115,634	1
2	Cash-Patient Deposits	(22,458)	(22,458)	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,511,771	2,511,771	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	131,327	131,327	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,687,920	\$ 2,736,274	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		1,300,000	14
15	Leasehold Improvements, at Historical Cost	471,961	471,961	15
16	Equipment, at Historical Cost	185,790	1,085,790	16
17	Accumulated Depreciation (book methods)	(164,487)	(749,806)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		5,206,743	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(404,970)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		673,250	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 493,264	\$ 7,682,968	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,181,184	\$ 10,419,242	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 726,386	\$ 743,971	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	560,897	560,897	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	WORKING CAPITAL	4,940,000	4,940,000	36
37	WORKING CAPITAL	840,688	840,688	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,067,971	\$ 7,085,556	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,442,944	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)	\$	\$ 5,442,944	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,067,971	\$ 12,528,500	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,886,787)	\$ (2,109,258)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,181,184	\$ 10,419,242	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,060,387)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,060,387)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(827,607)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,400,000	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) <u>related party propert co net income</u>	(398,793)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 173,600	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)	\$ (3,886,787)	24 *

* This must agree with page 17, line 47.

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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	\$ 7,106,079	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,106,079	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	257,904	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 257,904	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***	367	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 367	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>misc income</u>	1,286	28
28a	<u>related part property co income</u>	1,353,356	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,354,642	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,718,992	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	988,787	31
32	Health Care	3,167,331	32
33	General Administration	1,501,751	33
B. Capital Expense			
34	Ownership	2,890,366	34
C. Ancillary Expense			
35	Special Cost Centers	188,451	35
36	Provider Participation Fee	262,750	36
D. Other Expenses (specify):			
37	<u>BAD DEBT EXPENSE</u>	547,163	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,546,599	40
41	Income before Income Taxes (line 30 minus line 40)**	(827,607)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (827,607)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,364,968	44
45	Private Pay - Net Inpatient Revenue	407,386	45
46	Medicare - Net Inpatient Revenue	1,833,434	46
47	Other-(specify)	500,291	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,106,079	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.

Facility Name & ID Number Forest View Rehab & Nrsg Ctr

0051516

Report Period Beginning: 01/01/2014

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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	1,920	2,080	\$ 92,084	\$ 44.27	1
2	Assistant Director of Nursing	2,104	2,048	83,810	40.92	2
3	Registered Nurses	16,598	17,744	529,958	29.87	3
4	Licensed Practical Nurses	20,261	22,024	543,050	24.66	4
5	CNAs & Orderlies	61,043	67,521	852,625	12.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	7,604	8,134	89,835	11.04	9
10	Activity Assistants					10
11	Social Service Workers	1,968	2,080	49,140	23.63	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,952	16,629	190,730	11.47	15
16	Dishwashers					16
17	Maintenance Workers	4,090	4,304	65,589	15.24	17
18	Housekeepers	12,488	13,638	138,095	10.13	18
19	Laundry					19
20	Administrator	2,274	2,336	81,897	35.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,100	7,705	167,871	21.79	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	1,846	2,045	24,785	12.12	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	154,248	168,288	\$ 2,909,469 *	\$ 17.29	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	\$		35	
36	Medical Director			36	
37	Medical Records Consultant			37	
38	Nurse Consultant	659	32,955	10-3	38
39	Pharmacist Consultant	201	10,071	15-3	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	42	2,100	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	902	\$ 45,126		49

C. CONTRACT NURSES

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

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Forest View Rehab & Nrsg Ctr

0051516

Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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
- (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? n/a
- (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 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 40,738 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 262,750
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? 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: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? n/a
- (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.