

Facility Name & ID Number Forest City Rehab & Nrsg Ctr.

0052803 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3	114	Intermediate (ICF)	114	41,610	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	213	TOTALS	213	77,745	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,858	154	2,281	21,293	8
9	SNF/PED					9
10	ICF	42,184	343	3,609	46,136	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,042	497	5,890	67,429	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.73%

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

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 06/01/2014

J. Was the facility purchased or leased after January 1, 1978?
YES Date 08/24/2017 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 99 and days of care provided 2,281

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Forest City Rehab & Nrsng Ctr. # 0052803 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	299,284	45,781	11,280	356,345		356,345		356,345		1
2	Food Purchase		325,721		325,721		325,721	(2,266)	323,455		2
3	Housekeeping	275,050	31,196		306,246		306,246	5,248	311,494		3
4	Laundry	80,488	21,581		102,069		102,069		102,069		4
5	Heat and Other Utilities			159,021	159,021		159,021	(10,984)	148,037		5
6	Maintenance	43,690		80,331	124,021		124,021	379	124,400		6
7	Other (specify):*										7
8	TOTAL General Services	698,512	424,279	250,632	1,373,423		1,373,423	(7,623)	1,365,800		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	2,293,949	45,794	162,703	2,502,446		2,502,446	(42,330)	2,460,116		10
10a	Therapy	38,213	5,482		43,695		43,695		43,695		10a
11	Activities	136,914	12,276	2,524	151,714		151,714		151,714		11
12	Social Services	346,417	27	1,901	348,345		348,345		348,345		12
13	CNA Training										13
14	Program Transportation			371	371		371		371		14
15	Other (specify):*							16,278	16,278		15
16	TOTAL Health Care and Programs	2,815,493	63,579	174,699	3,053,771		3,053,771	(26,052)	3,027,719		16
	C. General Administration										
17	Administrative	80,806		556,800	637,606		637,606	(157,420)	480,186		17
18	Directors Fees										18
19	Professional Services			105,488	105,488	(725)	104,763	(19,791)	84,972		19
20	Dues, Fees, Subscriptions & Promotions			51,697	51,697		51,697	(13,172)	38,525		20
21	Clerical & General Office Expenses	80,809		120,639	201,448		201,448	199,815	401,263		21
22	Employee Benefits & Payroll Taxes			520,164	520,164		520,164		520,164		22
23	Inservice Training & Education										23
24	Travel and Seminar							3,315	3,315		24
25	Other Admin. Staff Transportation			982	982		982	9,375	10,357		25
26	Insurance-Prop.Liab.Malpractice			215,887	215,887		215,887	2,149	218,036		26
27	Other (specify):*							79,431	79,431		27
28	TOTAL General Administration	161,615		1,571,657	1,733,272	(725)	1,732,547	103,700	1,836,247		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,675,620	487,858	1,996,988	6,160,466	(725)	6,159,741	70,026	6,229,767		29

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

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

Facility Name & ID Number Forest City Rehab & Nrsg Ctr.

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Report Period Beginning:

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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			19,042	19,042		19,042	602,657	621,699			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,051	10,051		10,051	231,411	241,462			32
33	Real Estate Taxes			146,842	146,842	725	147,567	7,388	154,955			33
34	Rent-Facility & Grounds			962,565	962,565		962,565	(354,283)	608,282			34
35	Rent-Equipment & Vehicles			8,095	8,095		8,095		8,095			35
36	Other (specify):*											36
37	TOTAL Ownership			1,146,595	1,146,595	725	1,147,320	487,173	1,634,493			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		156,373	321,591	477,964		477,964		477,964			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			513,481	513,481		513,481		513,481			42
43	Other (specify):*			7,920	7,920		7,920	(7,920)				43
44	TOTAL Special Cost Centers		156,373	842,992	999,365		999,365	(7,920)	991,445			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,675,620	644,231	3,986,575	8,306,426		8,306,426	549,279	8,855,705			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 City Rehab & Nrsng Ctr.

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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	(14,386)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	597,611	30		9
10	Interest and Other Investment Income	(21,387)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(24)	02		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	(1,248)	21		18
19	Entertainment				19
20	Contributions	(1,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(30,615)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,818)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(296,068)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 227,065		\$	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)	322,214		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 322,214		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 549,279		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.			\$		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

BHF USE ONLY							
48		49		50		51	52

Forest City Rehab & Nrsg Ctr.

ID# 0052803

Report Period Beginning: 01/01/17

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Sequestration	\$ (18,320)	21	1
2	Vending Income	(5,501)	02	2
3	Miscellaneous Income	(4,225)	21	3
4	Marketing Expense	(7,920)	43	4
5	Bank Charges	(18,572)	21	5
6	PAC Dues	(14,511)	20	6
7	Building Company Bank Charges	(274)	21	7
8	Building Company Closing Costs	(192,391)	36	8
9	Building Company Professional Fees	(7,370)	19	9
10	Prior Period Software Costs	(18,867)	19	10
11	Capitalized R&M	(2,592)	06	11
12	Non-Allowable Legal Expense	(5,525)	19	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	(296,068)		49

Forest City Rehab & Nrsg Ctr.

Report Period Beginning: 01/01/17
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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	Total		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/17

Ending:

12/31/17

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													1
2	Food Purchase	(5,525)		2,800		459							(2,266)	2
3	Housekeeping			5,248									5,248	3
4	Laundry													4
5	Heat and Other Utilities	(14,386)		3,402									(10,984)	5
6	Maintenance	(2,592)		2,971									379	6
7	Other (specify):*													7
8	TOTAL General Services	(22,503)		14,421		459							(7,623)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records					89,103	(131,433)						(42,330)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					13,496	2,782						16,278	15
16	TOTAL Health Care and Programs					102,599	(128,651)						(26,052)	16
	C. General Administration													
17	Administrative			(133,888)			(23,532)						(157,420)	17
18	Directors Fees													18
19	Professional Services	(31,762)	7,370	2,305	185	511	1,601						(19,791)	19
20	Fees, Subscriptions & Promotions	(15,511)		2,208	46	85							(13,172)	20
21	Clerical & General Office Expenses	(79,072)	274	215,492		27,851	35,270						199,815	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			811		1,590	914						3,315	24
25	Other Admin. Staff Transportation			13		5,138	4,224						9,375	25
26	Insurance-Prop.Liab.Malpractice			1,330		819							2,149	26
27	Other (specify):*			40,492		3,109	35,829						79,431	27
28	TOTAL General Administration	(126,345)	7,644	128,762	231	39,103	54,306						103,700	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(148,848)	7,644	143,183	231	142,161	(74,345)						70,026	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Forest City Rehab & Nrsg Ctr. # 0052803 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	597,611		15	5,032								602,657	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(21,387)	249,531	1	3,266								231,411	32
33	Real Estate Taxes				7,388								7,388	33
34	Rent-Facility & Grounds		(381,842)	40,303	(12,744)								(354,283)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(192,391)	192,391											36
37	TOTAL Ownership	383,833	60,080	40,319	2,941								487,173	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(7,920)											(7,920)	43
44	TOTAL Special Cost Centers	(7,920)											(7,920)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	227,065	67,724	183,502	3,172	142,161	(74,345)						549,279	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
See Page 6- Supplemental		See Page 6- Supplemental		See Page 6- Supplemental		

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 381,842	Forest City Rehab & Nursing Center Realty LLC	100.00%	\$	\$ (381,842)	1
2	V	21 Bank Charges		Forest City Rehab & Nursing Center Realty LLC	100.00%	274	274	2
3	V	32 Interest Expense		Forest City Rehab & Nursing Center Realty LLC	100.00%	249,531	249,531	3
4	V	19 Professional Fees		Forest City Rehab & Nursing Center Realty LLC	100.00%	7,370	7,370	4
5	V	36 Closing Costs		Forest City Rehab & Nursing Center Realty LLC	100.00%	192,391	192,391	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 381,842			\$ 449,566	\$ * 67,724	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	2 DIETARY	\$	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	\$ 2,800	\$	2,800	15
16	V	3 HOUSEKEEPING		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	5,248		5,248	16
17	V	5 UTILITIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	3,402		3,402	17
18	V	6 REPAIRS AND MAINTENANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	2,971		2,971	18
19	V	17 S WEBSTER SALARY		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	27,661		27,661	19
20	V	17 Y LEVOVITZ-SALARY		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	24,050		24,050	20
21	V	19 PROFESSIONAL FEES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	2,305		2,305	21
22	V	20 DUES FEES SUBSCRIPTIONS		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	2,208		2,208	22
23	V	21 CLERICAL AND GENERAL		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	10,110		10,110	23
24	V	21 CLERICAL & GENERAL SALARIES		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	205,382		205,382	24
25	V	24 SEMINARS & EDUCATION		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	811		811	25
26	V	25 AUTO EXPENSE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	13		13	26
27	V	26 INSURANCE		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1,330		1,330	27
28	V	27 EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	40,492		40,492	28
29	V	30 DEPRECIATION		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	15		15	29
30	V	32 INTEREST		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	1		1	30
31	V	34 RENT		PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%	40,303		40,303	31
32	V	17 MANAGEMENT FEES	185,600	PREMIER HEALTHCARE & FINANCIAL SERVICES, INC.	100.00%			(185,600)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 185,600			\$ 369,102	\$ *	183,502	39

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

Facility Name & ID Number Forest City Rehab & Nrsg Ctr.

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Report Period Beginning: 01/01/17

Ending: 12/31/17

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	19 PROFESSIONAL FEES		PREMIER HC REAL ESTATE, LLC	100.00%	185	\$	185	15
16	V	20 LICENSES & PERMITS		PREMIER HC REAL ESTATE, LLC	100.00%	46		46	16
17	V	30 DEPRECIATION		PREMIER HC REAL ESTATE, LLC	100.00%	5,032		5,032	17
18	V	32 INTEREST EXPENSE		PREMIER HC REAL ESTATE, LLC	100.00%	3,266		3,266	18
19	V	33 REAL ESTATE TAXES		PREMIER HC REAL ESTATE, LLC	100.00%	7,388		7,388	19
20	V	34 RENTAL INCOME	12,744	PREMIER HC REAL ESTATE, LLC	100.00%			(12,744)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 12,744			\$ 15,916	\$ *	3,172	39

* 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	2 DIETARY	\$	iCare Consulting Services LLC	100.00%	\$ 459	\$	459	15
16	V	10 NURSING SALARIES	3,000	iCare Consulting Services LLC	100.00%	92,103		89,103	16
17	V	15 EMPLOYEE BEN. HC PROGRAMS		iCare Consulting Services LLC	100.00%	13,496		13,496	17
18	V	19 PROFESSIONAL FEES		iCare Consulting Services LLC	100.00%	511		511	18
19	V	20 DUES FEES SUBSCRIPTIONS		iCare Consulting Services LLC	100.00%	85		85	19
20	V	21 CLERICAL AND GENERAL		iCare Consulting Services LLC	100.00%	4,790		4,790	20
21	V	21 CLERICAL & GENERAL SALARIES		iCare Consulting Services LLC	100.00%	23,061		23,061	21
22	V	24 SEMINARS & EDUCATION		iCare Consulting Services LLC	100.00%	1,590		1,590	22
23	V	25 AUTO EXPENSE		iCare Consulting Services LLC	100.00%	5,138		5,138	23
24	V	26 INSURANCE		iCare Consulting Services LLC	100.00%	819		819	24
25	V	27 EMPLOYEE BEN. GEN ADMIN.		iCare Consulting Services LLC	100.00%	3,109		3,109	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 3,000			\$ 145,161	\$ *	142,161	39

* 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	10 NURSE CONSULANT SALARIES	146,716	SABA Healthcare	100.00%	15,283	\$ (131,433)
16	V	15 EMPLOYEE BEN. HC PROGRAMS		SABA Healthcare	100.00%	2,782	2,782
17	V	17 ADMIN SALARY -RELATED		SABA Healthcare	100.00%	185,125	185,125
18	V	17 ADMIN SALARY- NON RELATED		SABA Healthcare	100.00%	162,543	162,543
19	V	19 PROFESSIONAL FEES		SABA Healthcare	100.00%	1,601	1,601
20	V	21 CLERICAL AND GENERAL		SABA Healthcare	100.00%	1,006	1,006
21	V	21 CLERICAL & GENERAL SALARIES		SABA Healthcare	100.00%	34,264	34,264
22	V	24 SEMINARS & EDUCATION		SABA Healthcare	100.00%	914	914
23	V	25 AUTO EXPENSE		SABA Healthcare	100.00%	4,224	4,224
24	V	27 EMPLOYEE BEN. GEN ADMIN.		SABA Healthcare	100.00%	35,829	35,829
25	V	17 MANAGEMENT FEES	371,200	SABA Healthcare	100.00%		(371,200)
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 517,916			\$ 443,571	\$ * (74,345)

* 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number Forest City Rehab & Nrsg Ctr.

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Report Period Beginning: 01/01/17

Ending: 12/31/17

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number

Forest City Rehab & Nrsg Ctr.

0052803

Report Period Beginning:

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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	Shimon Webster	Owner	Administrative	9.68%	See Attached	7.39	18.48%	Alloc. Salary	\$ 27,661	17-7	1	
2	Yeruchom Levovitz	Owner	Administrative	8.28%	See Attached	7.39	18.48%	Alloc. Salary	24,050	17-7	2	
3	Kevin Chankin	Owner	A&G	2.35%	See Attached	7.39	18.48%	Alloc. Salary	36,930	21-7	3	
4	Moshe Blonder	Owner	Administrative	14.00%	See Attached	18.51	46.28%	Alloc. Salary	92,562	17-7	4	
5	Aharon Singer	Owner	Administrative	14.00%	See Attached	18.51	46.28%	Alloc. Salary	92,562	17-7	5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 273,765		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 & Nrsg Ctr.

0052803

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Forest City Rehab & Nrsrg Ctr.

0052803

Report Period Beginning:

01/01/17

Ending: 12/31/17

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 PREMIER HEALTHCARE & FINANCIAL SER
 Street Address 8131 MONTICELLO
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (773) 945-1000
 Fax Number (773) 751-2027

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	2	DIETARY	PATIENT DAYS	365,085	10	\$ 15,162	\$ 67,429	\$ 2,800	1
2	3	HOUSEKEEPING	PATIENT DAYS	365,085	10	28,415	67,429	5,248	2
3	5	UTILITIES	PATIENT DAYS	365,085	10	18,421	67,429	3,402	3
4	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	365,085	10	16,085	67,429	2,971	4
5	17	S WEBSTER SALARY	PATIENT DAYS	365,085	10	149,768	149,768	27,661	5
6	17	Y LEVOVITZ-SALARY	PATIENT DAYS	365,085	10	130,217	130,217	24,050	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	365,085	10	12,478	67,429	2,305	7
8	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	365,085	10	11,953	67,429	2,208	8
9	21	CLERICAL AND GENERAL	PATIENT DAYS	365,085	10	54,741	67,429	10,110	9
10	21	CLERICAL & GENERAL SALA	PATIENT DAYS	365,085	10	1,112,012	1,112,012	205,382	10
11	24	SEMINARS & EDUCATION	PATIENT DAYS	365,085	10	4,389	67,429	811	11
12	25	AUTO EXPENSE	PATIENT DAYS	365,085	10	69	67,429	13	12
13	26	INSURANCE	PATIENT DAYS	365,085	10	7,200	67,429	1,330	13
14	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	365,085	10	219,241	67,429	40,492	14
15	30	DEPRECIATION	PATIENT DAYS	365,085	10	79	67,429	15	15
16	32	INTEREST	PATIENT DAYS	365,085	10	4	67,429	1	16
17	34	RENT	PATIENT DAYS	365,085	10	218,217	67,429	40,303	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,998,451	\$ 1,391,997	\$ 369,102	25

Facility Name & ID Number Forest City Rehab & Nrsg Ctr.

0052803

Report Period Beginning:

01/01/17

Ending: 12/31/17

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 PREMIER HC REAL ESTATE, LLC
 Street Address 8131 MONTICELLO
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (773) 945-1000
 Fax Number (773) 751-2027

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	19	PROFESSIONAL FEES	PATIENT DAYS	365,085	10	1,000	67,429	185	1
2	20	LICENSES & PERMITS	PATIENT DAYS	365,085	10	250	67,429	46	2
3	30	DEPRECIATION	PATIENT DAYS	365,085	10	27,243	67,429	5,032	3
4	32	INTEREST EXPENSE	PATIENT DAYS	365,085	10	17,683	67,429	3,266	4
5	33	REAL ESTATE TAXES	PATIENT DAYS	365,085	10	40,000	67,429	7,388	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					\$ 86,176	\$	\$ 15,916	25

Facility Name & ID Number Forest City Rehab & Nrsg Ctr.

0052803

Report Period Beginning:

01/01/17

Ending: 12/31/17

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 iCare Consulting Services LLC
 Street Address 8131 Monticello
 City / State / Zip Code Skokie, IL 60076
 Phone Number (773) 945-1000
 Fax Number (773) 751-2027

1	2	3	4	5	6	7	8	9		
Schedule V	Unit of Allocation	(i.e.,Days, Direct Cost,	Total Units	Number of	Total Indirect	Amount of Salary	Facility	Allocation		
Line	Item	Square Feet)		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6		
Reference				Allocated Among	Allocated	in Column 6				
1	2	DIETARY	PATIENT DAYS	365,085	10	\$ 2,486	\$ 67,429	\$ 459	1	
2	10	NURSING SALARIES	PATIENT DAYS	365,085	10	498,679	498,679	67,429	92,103	2
3	15	EMPLOYEE BEN. HC PROGRA	PATIENT DAYS	365,085	10	73,073	67,429	13,496	3	
4	19	PROFESSIONAL FEES	PATIENT DAYS	365,085	10	2,768	67,429	511	4	
5	20	DUES FEES SUBSCRIPTIONS	PATIENT DAYS	365,085	10	459	67,429	85	5	
6	21	CLERICAL AND GENERAL	PATIENT DAYS	365,085	10	25,935	67,429	4,790	6	
7	21	CLERICAL & GENERAL SALA	PATIENT DAYS	365,085	10	124,859	124,859	67,429	23,061	7
8	24	SEMINARS & EDUCATION	PATIENT DAYS	365,085	10	8,610	67,429	1,590	8	
9	25	AUTO EXPENSE	PATIENT DAYS	365,085	10	27,819	67,429	5,138	9	
10	26	INSURANCE	PATIENT DAYS	365,085	10	4,434	67,429	819	10	
11	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	365,085	10	16,833	67,429	3,109	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					\$ 785,955	\$ 623,538	\$ 145,161	25	

Facility Name & ID Number Forest City Rehab & Nrsrg Ctr.

0052803

Report Period Beginning:

01/01/17

Ending: 12/31/17

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 8153 N. Lawndale
 City / State / Zip Code Skokie, IL 60076
 Phone Number (773) 945-1000
 Fax Number (773) 751-2027

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	10	NURSE CONSULANT SALARIE	PATIENT DAYS	145,694	6	33,022	33,022	67,429	15,283	1
2	15	EMPLOYEE BEN. HC PROGRA	PATIENT DAYS	145,694	6	6,012		67,429	2,782	2
3	17	ADMIN SALARY -RELATED	PATIENT DAYS	145,694	6	400,000	400,000	67,429	185,125	3
4	17	ADMIN SALARY- NON RELATI	PATIENT DAYS	145,694	6	351,207	351,207	67,429	162,543	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	145,694	6	3,459		67,429	1,601	5
6	21	CLERICAL AND GENERAL	PATIENT DAYS	145,694	6	2,173		67,429	1,006	6
7	21	CLERICAL & GENERAL SALA	PATIENT DAYS	145,694	6	74,035	74,035	67,429	34,264	7
8	24	SEMINARS & EDUCATION	PATIENT DAYS	145,694	6	1,975		67,429	914	8
9	25	AUTO EXPENSE	PATIENT DAYS	145,694	6	9,126		67,429	4,224	9
10	27	EMPLOYEE BEN. GEN ADMIN.	PATIENT DAYS	145,694	6	77,416		67,429	35,829	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					\$ 958,425	\$ 858,264	\$	443,571	25

Facility Name & ID Number Forest City Rehab & Nrsg Ctr.

0052803

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____

Fax Number (_____

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

Facility Name & ID Number Forest City Rehab & Nrsg Ctr.

0052803

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Forest City Rehab & Nrsg Ctr.

0052803

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Forest City Rehab & Nrsg Ctr.

0052803

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Forest City Rehab & Nrsg Ctr.

0052803

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

Forest City Rehab & Nrsg Ctr.

0052803

Report Period Beginning:

01/01/17

Ending:

12/31/17

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		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	MB Financial Bank		X	Mortgage			\$ 12,750,000	\$ 12,668,532			\$ 249,530	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	MB Financial Bank		X	Line of Credit		6/25/2014		465,000	7/15/2018	5.0000	10,051	6						
7	Allocated From Premier HC		X								1	7						
8	See Supplemental Schedule										3,266	8						
9	TOTAL Facility Related						\$ 12,750,000	\$ 13,133,532			\$ 262,848	9						
B. Non-Facility Related*																		
10	Interest Income		X								(21,387)	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (21,387)	14						
15	TOTALS (line 9+line14)						\$ 12,750,000	\$ 13,133,532			\$ 241,461	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

Facility Name & ID Number **Forest City Rehab & Nrsg Ctr.**

0052803

Report Period Beginning:

01/01/17

Ending:

12/31/17

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 2016 report.		\$	80,242	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.)		\$	132,352	2
3. Under or (over) accrual (line 2 minus line 1).		\$	52,110	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	102,120	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.)		\$	725	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.		\$	154,955	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012		8
	2013	123,071	9
	2014	123,952	10
	2015	126,540	11
	2016	124,964	12

Beginning accrual was adjusted to account for purchase of building during 2017

Allocated from Premier Realty: \$7,388

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2016	\$	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

Facility Name & ID Number Forest City Rehab & Nrsg Ctr.

0052803

Report Period Beginning:

01/01/17

Ending:

12/31/17

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: 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.

Table with 4 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost. Row 1: 1, 1, \$, 1. Row 2: 2, Allocated From Premier Realty, 3,509, 2. Row 3: 3, TOTALS, \$, 3,509, 3.

Facility Name & ID Number Forest City Rehab & Nrsg Ctr.

0052803

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	213		2017	1977	\$ 13,405,346	\$	39	\$ 343,727	\$ 343,727	\$ 343,727	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

*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 City Rehab & Nrsg Ctr.

0052803

Report Period Beginning:

01/01/17

Ending:

12/31/17

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			208,635	5,010	8,770	3,760	52,564	68				
69				19,042		(19,042)		69				
70		\$	13,613,981	\$	24,052	\$	352,497	\$	328,445	\$	396,291	70

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

Facility Name & ID Number Forest City Rehab & Nrsg Ctr.

0052803

Report Period Beginning:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 13,613,981	\$ 24,052		\$ 352,497	\$ 328,445	\$ 396,291	1
2	Aluminum Sign	2014	9,145		20	267	267	1,486	2
3	Interior/Exterior Painting, Soffits, Electrical, Doors, Lighting	2014	54,410		20	1,587	1,587	5,668	3
4	Pressure Control & Filter Drier For Freezer	2014	2,720		20	79	79	487	4
5	Expansion Valve, Compressor, Capacitators For Freezer	2014	3,514		20	103	103	615	5
6	New Water Heater # 2	2014	14,000		20	408	408	2,217	6
7	Therapy Workstations, Electric For Sign, Doors	2014	8,545		20	249	249	1,353	7
8	Elevator-New Cylinder, Pistons, Protective Covering, Oil Line, Va	2015	24,500		20	715	715	4,288	8
9	Bathroom/Therapy - Piping, Door, Framing, Plumbing Repair	2015	6,780		20	198	198	960	9
10	Water Heater With New 20 Gallon Holding Tank	2015	21,657		20	632	632	2,256	10
11	Compressor Replacement On Freezer	2015	3,116		20	91	91	415	11
12	Dumpster Enclosure/Fencing With Gates, Steel Frames, 4 Inch Po	2017	5,500		20	214	214	306	12
13	Replaced Heat Exchanger,Collector Box, And Inducer Fan For He	2017	2,592		20	130	130	130	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 13,770,460	\$ 24,052		\$ 357,168	\$ 333,116	\$ 416,471	34

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

Facility Name & ID Number Forest City Rehab & Nrsg Ctr.

0052803

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	
1		\$ 13,770,460	\$ 24,052		\$ 357,168	\$ 333,116	\$ 416,471	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		\$ 13,770,460	\$ 24,052		\$ 357,168	\$ 333,116	\$ 416,471	34

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

Facility Name & ID Number Forest City Rehab & Nrsg Ctr.

0052803

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	
1		\$ 13,770,460	\$ 24,052		\$ 357,168	\$ 333,116	\$ 416,471	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		\$ 13,770,460	\$ 24,052		\$ 357,168	\$ 333,116	\$ 416,471	34

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

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
1		\$ 13,770,460	\$ 24,052		\$ 357,168	\$ 333,116	\$ 416,471
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$ 13,770,460	\$ 24,052		\$ 357,168	\$ 333,116	\$ 416,471

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

Facility Name & ID Number Forest City Rehab & Nrsg Ctr.

0052803

Report Period Beginning:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Forest City Rehab & Nrsg Ctr.

0052803

Report Period Beginning:

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Ending:

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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	
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	TOTAL (lines 1 thru 33)	\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated From Premier Realty	2011	68,782	1,764	35	1,965	201	11,953	3
4	Allocated From Premier Realty	2012	8,757	224	35	250	26	1,502	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocated From Premier Realty	2011	122,332	2,915	20	6,117	3,202	37,210	10
11	Allocated From Premier Realty	2012	3,546	91	20	177	86	1,064	11
12									12
13	Allocated From Premier HC & Financial Services	2012	1,561	16	20	78	62	469	13
14	Allocated From Premier HC & Financial Services	2016	3,657		20	183	183	366	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 208,635	\$ 5,010		\$ 8,770	\$ 3,760	\$ 52,564	34

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

Facility Name & ID Number Forest City Rehab & Nrsg Ctr.

0052803

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	
1		\$ 208,635	\$ 5,010		\$ 8,770	\$ 3,760	\$ 52,564	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	TOTAL (lines 1 thru 33)	\$ 208,635	\$ 5,010		\$ 8,770	\$ 3,760	\$ 52,564	34

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

Facility Name & ID Number Forest City Rehab & Nrsng Ctr.

0052803

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	\$ 88,839	\$ 37	\$ 7,431	\$ 7,394	10	\$ 42,160	71
72	Current Year Purchases	2,572,359		257,100	257,100	10	257,100	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,661,198	\$ 37	\$ 264,532	\$ 264,495		\$ 299,260	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)	\$ 16,435,167	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 24,089	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 621,700	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 597,611	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 715,731	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 City Rehab & Nrsng Ctr.

0052803

Report Period Beginning: 01/01/17

Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Fairview Nursing Property

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		<u>213</u>		\$ <u>580,722</u>			3
4	Additions							4
5								5
6	<u>Allocated From Premier HC</u>				<u>27,559</u>			6
7	TOTAL		213		\$ 608,281			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.	<u> /2018</u>	\$ _____
13.	<u> /2019</u>	\$ _____
14.	<u> /2020</u>	\$ _____

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: \$ 8,095 Description: See Attached Schedule

(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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	138,117	\$		\$	138,117	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				49,155				49,155	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				131,222				131,222	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescrpts					42,356			42,356	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify):						3,097	114,017			117,114	13
14	TOTAL			\$		\$	321,591	\$	156,373	\$	477,964	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/17

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 47,575	\$ 56,489	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,412,207	1,412,207	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	121,095	121,095	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	5,677	68,159	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,586,554	\$ 1,657,950	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		13,405,346	14
15	Leasehold Improvements, at Historical Cost	152,285	152,285	15
16	Equipment, at Historical Cost	21,553	2,591,207	16
17	Accumulated Depreciation (book methods)	(54,977)	(54,977)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	1,266,018	1,347,310	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,384,879	\$ 17,441,171	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,971,433	\$ 19,099,121	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 394,639	\$ 394,638	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	465,000	465,000	29
30	Accrued Salaries Payable	212,791	212,791	30
31	Accrued Taxes Payable (excluding real estate taxes)	230	230	31
32	Accrued Real Estate Taxes(Sch.IX-B)		102,120	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	151,868	151,868	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,224,528	\$ 1,326,647	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,668,532	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>		3,424,761	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 16,093,293	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,224,528	\$ 17,419,940	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,746,905	\$ 1,679,181	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,971,433	\$ 19,099,121	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,132,504	1
2	Restatements (describe):		2
3	2016 Depreciation/FA Adjustment	52,686	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,185,190	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	981,215	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	(1,419,500)	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)	\$ (438,285)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,746,905	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Forest City Rehab & Nrsng Ctr.

0052803

Report Period Beginning: 01/01/17

Ending:

12/31/17

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	\$ 9,128,140	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,128,140	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***	21,387	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 21,387	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	138,114	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 138,114	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,287,641	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,373,423	31
32	Health Care	3,053,771	32
33	General Administration	1,733,272	33
B. Capital Expense			
34	Ownership	1,146,595	34
C. Ancillary Expense			
35	Special Cost Centers	485,884	35
36	Provider Participation Fee	513,481	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,306,426	40
41	Income before Income Taxes (line 30 minus line 40)**	981,215	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 981,215	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,458,912	44
45	Private Pay - Net Inpatient Revenue	102,578	45
46	Medicare - Net Inpatient Revenue	1,039,283	46
47	Other-(specify) <u>Hospice</u>	435,051	47
48	Other-(specify) <u>Commercial</u>	92,316	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,128,140	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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 City Rehab & Nrsg Ctr.

0052803

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	1,728	1,816	\$ 66,221	\$ 36.47	1
2	Assistant Director of Nursing	1,920	2,080	73,181	35.18	2
3	Registered Nurses	13,739	14,753	395,898	26.84	3
4	Licensed Practical Nurses	29,277	31,036	737,751	23.77	4
5	CNAs & Orderlies	72,998	79,733	995,036	12.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,766	3,536	38,213	10.81	8
9	Activity Director	1,976	2,064	32,937	15.96	9
10	Activity Assistants	8,941	9,802	103,977	10.61	10
11	Social Service Workers	21,379	22,781	346,417	15.21	11
12	Dietician					12
13	Food Service Supervisor	1,981	2,080	55,224	26.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,648	22,896	244,060	10.66	15
16	Dishwashers					16
17	Maintenance Workers	3,032	3,272	43,690	13.35	17
18	Housekeepers	22,018	24,203	275,050	11.36	18
19	Laundry	7,438	8,129	80,488	9.90	19
20	Administrator	1,992	2,080	80,806	38.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,637	7,128	80,809	11.34	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	1,981	2,145	25,862	12.06	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	220,451	239,534	\$ 3,675,620 *	\$ 15.34	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	240	\$ 11,280	01-03	35
36	Medical Director	Monthly	7,200	09-03	36
37	Medical Records Consultant	Monthly	1,872	10-03	37
38	Nurse Consultant	Monthly	149,716	10-03	38
39	Pharmacist Consultant	Monthly	11,115	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	49	2,524	11-03	44
45	Social Service Consultant	30	1,901	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	319	\$ 185,608		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. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Paul Michalsen	Administrator	0.00%	\$ 80,806	Workers' Compensation Insurance	\$ 75,158	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	70,741	Advertising: Employee Recruitment	2,095		
				FICA Taxes	272,656	Health Care Worker Background Check (Indicate # of checks performed <u>689</u>)	6,894		
				Employee Health Insurance	90,930	Patient Background Checks			
				Employee Meals		Dues & Subscriptions	14,512		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses and Fees	10,693		
				Other Employee Benefits	9,895	Allocated From Premier HC & Financial	2,208		
				Christmas Expense	785	Allocated From Premier Realty	46		
						See Supplemental Schedule	85		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 80,806			Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 38,523		
B. Administrative - Other									
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			\$ 520,165		
Management Fees- Premier HC & Financial Services			\$ 185,600						
Management Fees- SABA Healthcare			371,200						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 556,800						
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
See Attached	Legal		\$ 17,891				Out-of-State Travel	\$	
MTS Consulting	Accounting		3,727						
Creative Technology Solutions	Data Processing		8,416				In-State Travel		
Prospect Resources	Natural Gas Procurement		600						
Point Click Care	Data Processing		37,419				Seminar Expense		
Marcum LLP	Accounting		18,121				Allocated From iCare	1,590	
Mowery & Schoenfeld	Benefit Plan Audit		1,643				Allocated From SABA Healthcare	914	
Zirmed	Revenue Cycle Mgmt		679				See Supplemental Schedule	811	
Experian	Credit Checks		462				Entertainment Expense	()	
Reliable Health Systems	Computer Services		16,530				TOTAL (agree to Sch. V, line 24, col. 8)	\$ 3,315	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 105,488	TOTAL			\$		

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Forest City Rehab & Nrsng Ctr.# 0052803

Report Period Beginning:

01/01/17

Ending:

12/31/17**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. IL Council LTC \$29,023
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 33,557 Line 10-02
- (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 No NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO No If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 513,481
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. \$ N/A 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? 100% ln 14
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? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees