



Facility Name & ID Number Forest View Rehab & Nrsg Ctr

# 0051516 Report Period Beginning: 1/1/17 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	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	17,904	505	4,643	23,052	8
9	SNF/PED					9
10	ICF	16,020	451	1,752	18,223	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,924	956	6,395	41,275	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.53%

D. How many bed reserve days during this year were paid by the Department? 0 (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)  
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

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

I. On what date did you start providing long term care at this location?  
Date started 6/1/11

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 6/1/11 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 14 and days of care provided 2,684

Medicare Intermediary National Government Services

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/17 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
	<b>A. General Services</b>										
1	Dietary	233,330	23,176	10,830	267,336		267,336	(1,309)	266,027		1
2	Food Purchase		229,418		229,418		229,418	1,236	230,654		2
3	Housekeeping	196,794	25,849		222,643		222,643	374	223,017		3
4	Laundry	51,823	15,587		67,410		67,410		67,410		4
5	Heat and Other Utilities			344,459	344,459		344,459	504	344,963		5
6	Maintenance	33,391	23,461	52,037	108,889		108,889	425	109,314		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	515,338	317,491	407,326	1,240,155		1,240,155	1,230	1,241,385		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			34,500	34,500		34,500		34,500		9
10	Nursing and Medical Records	2,828,683	189,980	55,668	3,074,331		3,074,331	(13,122)	3,061,209		10
10a	Therapy			674,714	674,714		674,714		674,714		10a
11	Activities	145,941	13,115		159,056		159,056		159,056		11
12	Social Services	61,263		9,654	70,917		70,917		70,917		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Pharmacy Consult</b>			13,122	13,122		13,122	(241)	12,881		15
16	<b>TOTAL Health Care and Programs</b>	3,035,887	203,095	787,658	4,026,640		4,026,640	(13,363)	4,013,277		16
	<b>C. General Administration</b>										
17	Administrative	79,985			79,985		79,985		79,985		17
18	Directors Fees										18
19	Professional Services			324,563	324,563		324,563	(163,899)	160,664		19
20	Dues, Fees, Subscriptions & Promotions			14,572	14,572		14,572	178	14,750		20
21	Clerical & General Office Expenses	197,486	86,076	101,860	385,422		385,422	88,992	474,414		21
22	Employee Benefits & Payroll Taxes			628,963	628,963		628,963	29,628	658,591		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,634	4,634		4,634	3,621	8,255		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			207,497	207,497		207,497	27,636	235,133		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	277,471	86,076	1,282,089	1,645,636		1,645,636	(13,844)	1,631,792		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,828,696	606,662	2,477,073	6,912,431		6,912,431	(25,977)	6,886,454		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 &amp; ID Number

Forest View Rehab &amp; Nrsg Ctr

#0051516

Report Period Beginning:

1/1/17

Ending:

12/31/17

## 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	
	<b>D. Ownership</b>											
30	Depreciation			68,868	68,868		68,868	236,460	305,328			30
31	Amortization of Pre-Op. & Org.							229,963	229,963			31
32	Interest			123,781	123,781		123,781	176,834	300,615			32
33	Real Estate Taxes			76,623	76,623		76,623		76,623			33
34	Rent-Facility & Grounds			1,127,656	1,127,656		1,127,656	(1,122,851)	4,805			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,396,928	1,396,928		1,396,928	(479,594)	917,334			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			1,160	1,160		1,160		1,160			38
39	Ancillary Service Centers		129,224		129,224		129,224	(2,191)	127,033			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			310,670	310,670		310,670		310,670			42
43	Other (specify):* <b>Bad Debt Exp.</b>			182,838	182,838		182,838	(182,838)				43
44	<b>TOTAL Special Cost Centers</b>		129,224	494,668	623,892		623,892	(185,029)	438,863			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,828,696	735,886	4,368,669	8,933,251		8,933,251	(690,600)	8,242,651			45

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

**VI. ADJUSTMENT DETAIL**

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

		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	94,975	30		9
10	Interest and Other Investment Income	(5,769)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(25)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(25)	21		18
19	Entertainment				19
20	Contributions	(7,142)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(182,838)	43		24
25	Fund Raising, Advertising and Promotional	(24,398)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,833)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (129,055)		\$	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)	(561,545)	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (561,545)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (690,600)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY							
48		49		50		51	52

Forest View Rehab & Nrsg Ctr

ID# 0051516

Report Period Beginning: 1/1/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Misc Income	\$ (752)	21	1
2	Lobbying	(475)	20	2
3	Collection Costs	(140)	21	3
4	RP Profit	(34)	10	4
5	RP Profit	(241)	15	5
6	RP Profit	(2,191)	39	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	<b>Total</b>	(3,833)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Forest View Rehab & Nrsg Ctr

# 0051516

Report Period Beginning:

1/1/17

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	(25)	(1,284)	0	0	0	0	0	0	0	0	0	(1,309)	1
2	Food Purchase	0	1,236	0	0	0	0	0	0	0	0	0	1,236	2
3	Housekeeping	0	374	0	0	0	0	0	0	0	0	0	374	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	504	0	0	0	0	0	0	0	0	0	504	5
6	Maintenance	0	425	0	0	0	0	0	0	0	0	0	425	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(25)</b>	<b>1,255</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,230</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(34)	(13,088)	0	0	0	0	0	0	0	0	0	(13,122)	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):*	(241)	0	0	0	0	0	0	0	0	0	0	(241)	15
16	<b>TOTAL Health Care and Programs</b>	<b>(275)</b>	<b>(13,088)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(13,363)</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(167,599)	3,700	0	0	0	0	0	0	0	0	(163,899)	19
20	Fees, Subscriptions & Promotions	(475)	653	0	0	0	0	0	0	0	0	0	178	20
21	Clerical & General Office Expenses	(32,457)	121,199	250	0	0	0	0	0	0	0	0	88,992	21
22	Employee Benefits & Payroll Taxes	0	29,628	0	0	0	0	0	0	0	0	0	29,628	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,621	0	0	0	0	0	0	0	0	0	3,621	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	608	27,028	0	0	0	0	0	0	0	0	27,636	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(32,932)</b>	<b>(11,890)</b>	<b>30,978</b>	<b>0</b>	<b>(13,844)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(33,232)</b>	<b>(23,723)</b>	<b>30,978</b>	<b>0</b>	<b>(25,977)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/17 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	94,975	134	141,351	0	0	0	0	0	0	0	0	236,460	30
31	Amortization of Pre-Op. & Org.	0	0	229,963	0	0	0	0	0	0	0	0	229,963	31
32	Interest	(5,769)	0	182,603	0	0	0	0	0	0	0	0	176,834	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(1,122,851)	0	0	0	0	0	0	0	0	(1,122,851)	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	<b>TOTAL Ownership</b>	<b>89,206</b>	<b>134</b>	<b>(568,934)</b>	<b>0</b>	<b>(479,594)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(2,191)	0	0	0	0	0	0	0	0	0	0	(2,191)	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):*	(182,838)	0	0	0	0	0	0	0	0	0	0	(182,838)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(185,029)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(185,029)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(129,055)</b>	<b>(23,589)</b>	<b>(537,956)</b>	<b>0</b>	<b>(690,600)</b>	<b>45</b>							

**VII. RELATED PARTIES**

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

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

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$ 3,685	Infinity Healthcare Management of Illinois		\$ 2,401	\$ (1,284)	1
2	V	2 Food Purchase		Infinity Healthcare Management of Illinois		1,236	1,236	2
3	V	3 Housekeeping		Infinity Healthcare Management of Illinois		374	374	3
4	V	5 Utilities		Infinity Healthcare Management of Illinois		504	504	4
5	V	6 Maintenance		Infinity Healthcare Management of Illinois		425	425	5
6	V	10 Nursing	55,668	Infinity Healthcare Management of Illinois		42,580	(13,088)	6
7	V	19 Activities	277,135	Infinity Healthcare Management of Illinois		109,536	(167,599)	7
8	V	20 Dues & Fees		Infinity Healthcare Management of Illinois		653	653	8
9	V	21 Office Expense	96,471	Infinity Healthcare Management of Illinois		217,670	121,199	9
10	V	22 Employee Benefits		Infinity Healthcare Management of Illinois		29,628	29,628	10
11	V	24 Travel Expense		Infinity Healthcare Management of Illinois		3,621	3,621	11
12	V	26 Insurance		Infinity Healthcare Management of Illinois		608	608	12
13	V	30 Depreciation		Infinity Healthcare Management of Illinois		134	134	13
14	Total		\$ 432,959			\$ 409,370	\$ * (23,589)	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	32 Interest	\$	Infinity Healthcare Management		\$ 14	\$	14	15
16	V	34 Rent		Infinity Healthcare Management		4,805		4,805	16
17	V								17
18	V	19 Professional Fees		Forest View Nursing Realty, LLC		3,700		3,700	18
19	V	21 Office Expense		Forest View Nursing Realty, LLC		250		250	19
20	V	26 Insurance		Forest View Nursing Realty, LLC		27,028		27,028	20
21	V	30 Depreciation		Forest View Nursing Realty, LLC		141,351		141,351	21
22	V	31 Amortization		Forest View Nursing Realty, LLC		229,963		229,963	22
23	V	32 Interest		Forest View Nursing Realty, LLC		182,589		182,589	23
24	V	33 Property Tax		Forest View Nursing Realty, LLC					24
25	V	34 Rent	1,127,656	Forest View Nursing Realty, LLC				(1,127,656)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 1,127,656			\$ 589,700	\$ *	(537,956)	39

\* 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:

1/1/17

Ending:

12/31/17

**VII. RELATED PARTIES**

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

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

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/17 Ending: 12/31/17

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:

1/1/17

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Forest View Rehab & Nrsg Ctr

# 0051516

Report Period Beginning:

1/1/17

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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	HUD Loan		X	Mortgage	\$21,777.00	6/26/14	\$ 5,089,300	\$ 4,832,814	6/1/49	3.7500	\$ 182,588	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6	Capital One		X	Working Capital	None	Various	Various	5,764,392	None	Various	123,238	6						
7	Infinity Funding	X		Working Capital	None	Various	Various	8,631	None	Various	558	7						
8												8						
9	<b>TOTAL Facility Related</b>				\$21,777.00		\$ 5,089,300	\$ 10,605,837			\$ 306,384	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 5,089,300	\$ 10,605,837			\$ 306,384	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ 27,028      Line # 26

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

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

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

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2016 report.		\$	<b>(85,526)</b>	<b>1</b>
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.)		\$	<b>70,415</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>155,941</b>	<b>3</b>
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>(79,318)</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>76,623</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2012</b>	<b>63,538</b>	<b>8</b>
	<b>2013</b>	<b>62,180</b>	<b>9</b>
	<b>2014</b>	<b>62,431</b>	<b>10</b>
	<b>2015</b>	<b>70,117</b>	<b>11</b>
	<b>2016</b>	<b>70,415</b>	<b>12</b>

**FOR BHF USE ONLY**

<b>13</b>	FROM R. E. TAX STATEMENT FOR 2016	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**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.**

**2016 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Forest View Rehab & Nrsg Ctr COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0051516

CONTACT PERSON REGARDING THIS REPORT Daniel S. Gaafar

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

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2016 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 2016.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>03-17-102-040</u>	<u>Nursing Facility</u>	\$ <u>2,406.00</u>	\$ <u>2,406.00</u>
2. <u>03-17-102-041</u>	<u>Nursing Facility</u>	\$ <u>33,544.00</u>	\$ <u>33,544.00</u>
3. <u>03-17-102-045</u>	<u>Nursing Facility</u>	\$ <u>34,465.00</u>	\$ <u>34,465.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>70,415.00</u></u>	\$ <u><u>70,415.00</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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number Forest View Rehab & Nrsg Ctr

# 0051516 Report Period Beginning:

1/1/17 Ending:

12/31/17

**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).

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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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Land		2013	\$ 27,060	1
2	Land		2015	478,290	2
3	TOTALS			\$ 505,350	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	\$	\$ 121,058	4
5		2015		451,940	11,588	39	11,588		28,569	5
6		2013		4,400,420		39				6
7		2015		(451,940)						7
8										8
	<b>Improvement Type**</b>									
9	Install Metal Sheet Inside Roof	2011		1,402	36	39	36		237	9
10	Painting and Drywall	2011		2,559	66	39	66		433	10
11	Install TV Jacks in Every Room	2011		18,744	481	39	481		3,022	11
12	Install Sprinkler Head in Elevator Shaft	2011		1,485	38	39	38		251	12
13	Build & Install Exterior Sign	2011		6,435	165	39	165		1,087	13
14	Remove Old Fans and Paint Walls	2011		1,100	28	39	28		185	14
15										15
16	Remove and Replace Fire Sprinklers	2012		9,683	248	39	248		1,489	16
17	Remodel Resident Bathrooms	2012		12,905	331	39	331		1,986	17
18	Remodel Dining Room	2012		4,085	105	39	105		629	18
19	New phones and wiring	2012								19
20	Install new TV jacks	2012		3,750	96	39	96		576	20
21	Install exhaust fans in bathrooms	2012		1,950	50	39	50		300	21
22	Install new outlets throughout bedrooms	2012		9,980	256	39	256		1,536	22
23	Remodel lobby, vestibule, hallway, etc.	2012		226,000	5,795	39	5,795		34,768	23
24	Install fire dampers in exhaust fans	2012		40,423	1,036	39	1,036		6,217	24
25	Connect electricity for sign light	2012		2,043	52	39	52		313	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 &amp; ID Number Forest View Rehab &amp; Nrsng Ctr

# 0051516

Report Period Beginning:

1/1/17

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	
37	Painting on 1st floor resident rooms	2013	\$ 2,725	\$ 70	39	\$ 70	\$	\$ 315	37
38	Tub removal, new tiles on 1st floor	2013	650	17	39	17		76	38
39	Install cove base on 1st floor	2013	300	8	39	8		36	39
40	Water Heater	2013	3,455	89	39	89		400	40
41	Roof work due to leak	2013	2,900	74	39	74		334	41
42	Modify emergency panel for 2 phase 120/208 service & transforme	2013	9,650	247	39	247		1,112	42
43	Johnsite silhouette Base, light Oak Wall Art rubber wall base	2013	2,400	62	39	62		278	43
44	Plumbing, lights, cove base, paint, ceiling tiles in copy room	2013	3,100	79	39	79		356	44
45	Flooring and cove base in 5 resident rooms	2012	12,100	310	39	310		1,311	45
46	Lighting in vestibule, chrome grids for elevator, signage	2013	1,300	33	39	33		149	46
47	Waste line, electrical in ceiling and A/C work in Lobby	2013	4,000	103	39	103		463	47
48	Sprinkler work, pipe inspection, relocate sprinkler heads	2013	8,994	231	39	231		1,038	48
49	Pump motor and bearings in water heater boiler.	2013	2,467	63	39	63		284	49
50	Cubicle curtains	2013	1,097	28	39	28		126	50
51	Replace asphalt	2013	2,550	65	39	65		293	51
52	Open wall, replace pips on 1st floor	2013	1,500	38	39	38		172	52
53	Opened 40'x16' roof area and sealed	2013	2,379	61	39	61		275	53
54									54
55	Chicago Pro - stell exterior door	2014	13,999	359	39	359		1,436	55
56	Hinsdale Tile & Carpet - 3rd floor corridors tile	2014	4,874	125	39	125		500	56
57	Superior Construction - replace 2nd floor hallway carpet	2014			39				57
58	Cybor Fire - fire sprinklers	2014	2,891	74	39	74		296	58
59	Superior Construction - replace 2nd floor hallway carpet	2014	4,990	128	39	128		512	59
60	C.S.R. - patch cracks on main driveway	2014	2,100	54	39	54		216	60
61	Greenview Construction - replace masonry walls & doors	2014	4,217	108	39	108		432	61
62	Suburban Elevator - furnishh & instill door restrictors	2014	2,980	76	39	76		304	62
63	Valley Fire Protection - replace pipes with cast iron	2014	4,700	121	39	121		484	63
64	Valley Fire Protection - gas water heaters	2014	13,000	333	39	333		1,332	64
65	Precision Heating - generator room duct work	2014	2,265	58	39	58		232	65
66	Superior Construction - replace tiles & open kitchen wall	2014	4,512	116	39	116		464	66
67	Precision Heating - air louver for heating boilers	2014	3,855	99	39	99		396	67
68	Cary Supply - new wander system	2014	3,467	89	39	89		356	68
69	Replace bedroom floor tile	2014			39				69
70	TOTAL (lines 4 thru 69)		\$ 6,172,382	\$ 57,022		\$ 57,022	\$	\$ 216,634	70

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

Facility Name &amp; ID Number Forest View Rehab &amp; Nrsg Ctr

# 0051516

Report Period Beginning:

1/1/17

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	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	<b>Totals from Page 12A, Carried Forward</b>		\$ 6,172,382	\$ 57,022		\$ 57,022		\$ 216,634	1
2	Furnish and install one standard pit ladder per elevator	2015	3,900	100	39	100		200	2
3	Inspect and clean all fire dampers in the building	2015	2,758	71	39	71		213	3
4	Apply patches to the north and south sections of the roof	2015			39				4
5	Paint rooms 134,137,147,149,150,152,237 & conf. rm	2015	3,250	83	39	83		249	5
6	Repair and repave parking lot	2015	39,000	1,000	39	1,000		3,000	6
7	Repair south canopy ceiling, brick, and metal drip edge	2015	3,950	101	39	101		303	7
8	Repair or replace damaged shingles	2015	3,950	101	39	101		303	8
9	Apply patch to the field/wall flashings (North & South sect.)	2015	6,021	155	39	154	(1)	465	9
10	Renovate 2nd Flr - Replace floor, cove base, chair rail, and								10
11	wallcoverings in dining room. Paint doors/windows and add								11
12	furnishings in dining room. Replace floor, cove base,								12
13	handrails, ceiling lighting, wallpaper, and signage in hallway.								13
14	Paint doors/windows and add furnishings in hallway.	2015	140,347	3,598	39	3,599	1	10,794	14
15	Install new circuit breaker system	2015	14,100	362	39	362		1,086	15
16									16
17	Install dedicated generator line 2nd floor	2016	1,375	35	39	35		70	17
18	Replace therapy room windows	2016	5,000	128	39	128		256	18
19	Paint kitchen, therapy room, & day room	2016	2,550	65	39	65		130	19
20	Stain railings on entire 2nd floor	2016	1,980	51	39	51		102	20
21	Replace fire alarm system hardware	2016	5,900	151	39	151		302	21
22	Doors for 1st floor main entrance, 2nd floor N exit and hallway	2016	4,374	112	39	112		224	22
23	New facility surveillance cameras	2016	5,000	128	39	128		256	23
24	DISPOSAL - Pit ladders from FY 15	2016	(3,900)	(100)	39	(100)		(200)	24
25	DISPOSAL - Roof repair (repair south canopy ceiling) from FY 15	2016	(3,950)	(101)	39	(101)		(202)	25
26	IDPH Capital Report Adjustments 6/30/16	2016	(170,898)						26
27									27
28	B&G Replacement Pump Assembly for South End of Building	2017	3,237	43	39	83	40	43	28
29	Picture Windows for North & South sides of Building	2017	3,747	48	39	96	48	48	29
30	Life Safety Panels for North & South Building	2017	9,300	119	39	238	119	119	30
31	Door Wreck for elevator	2017	2,600	33	39	67	34	33	31
32	New Cylinder Elevator One	2017	27,500	353	39	705	352	353	32
33	Ceiling & Wall Speakers for Overhead Paging on 2nd Floor	2017	3,132	40	39	80	40	40	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,286,605	\$ 63,698		\$ 64,331	\$ 633	\$ 234,821	34

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

Facility Name & ID Number Forest View Rehab & Nrsg Ctr

# 0051516

Report Period Beginning:

1/1/17

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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	\$ 1,173,371	\$ 140,332	\$ 234,674	\$ 94,342	5-7	\$ 1,175,320	71
72	Current Year Purchases	31,616	6,323	6,323		5	6,323	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,204,987	\$ 146,655	\$ 240,997	\$ 94,342		\$ 1,181,643	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)	\$ 7,996,942	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 210,353	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 305,328	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 94,975	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,416,464	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: 1/1/17

Ending: 12/31/17

**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	<b>TOTAL</b>				\$			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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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	<b>TOTAL</b>		\$	\$	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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	\$	3,651	\$ 246,809	\$	3,651	\$ 246,809	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,504	116,895		1,504	116,895	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		5,607	311,010		5,607	311,010	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				119,297		119,297	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>X-ray &amp; Lab</u>	39-2					9,927		9,927	12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	10,762	\$ 674,714	\$ 129,224	10,762	\$ 803,938	14

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

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (137,584)	\$ 328,480	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	2,631,470	2,631,470	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	144,924	144,924	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Escrow Accounts</u>		49,533	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,638,810	\$ 3,154,407	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		505,350	13
14	Buildings, at Historical Cost		1,751,940	14
15	Leasehold Improvements, at Historical Cost	757,081	757,081	15
16	Equipment, at Historical Cost	304,987	1,204,987	16
17	Accumulated Depreciation (book methods)	(366,838)	(1,416,464)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	113,171	3,562,624	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(1,075,335)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Replacement reserves</u> )	102,336	487,783	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 910,737	\$ 5,777,966	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,549,547	\$ 8,932,373	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,185,057	\$ 1,267,349	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,026	8,026	28
29	Short-Term Notes Payable		81,484	29
30	Accrued Salaries Payable	217,552	217,552	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,084	20,084	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		15,103	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Working capital</u>	5,764,392	5,764,392	36
37	<u>Working capital</u>	8,631	8,631	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 7,203,742	\$ 7,382,621	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		4,751,330	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 4,751,330	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 7,203,742	\$ 12,133,951	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (3,654,195)	\$ (3,201,578)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,549,547	\$ 8,932,373	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(3,717,728)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(3,717,728)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>203,533</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(140,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>63,533</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(3,654,195)</b>	<b>24</b> *

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

Facility Name &amp; ID Number Forest View Rehab &amp; Nrsg Ctr

# 0051516

Report Period Beginning: 1/1/17

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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,788,398	1
2	Discounts and Allowances for all Levels	639,395	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,427,793	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	610,059	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 610,059	8
<b>C. Other Operating Revenue</b>			
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	79,656	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,040	19
20	Radiology and X-Ray	8,423	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 93,119	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	5,060	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 5,060	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<b>Misc Revenue</b>	752	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 752	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,136,783	30

2			
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,240,155	31
32	Health Care	4,026,639	32
33	General Administration	1,645,635	33
<b>B. Capital Expense</b>			
34	Ownership	1,396,929	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	129,224	35
36	Provider Participation Fee	310,670	36
<b>D. Other Expenses (specify):</b>			
37	<u>Bad Debt Expense</u>	182,838	37
38	<u>Medically Necessary Transportation</u>	1,160	38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,933,250	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	203,533	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 203,533	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 6,193,347	44
45	Private Pay - Net Inpatient Revenue	216,805	45
46	Medicare - Net Inpatient Revenue	1,244,845	46
47	Other-(specify)	772,796	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 8,427,793	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:

1/1/17

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	2,103	2,224	\$ 107,197	\$ 48.20	1
2	Assistant Director of Nursing	4,593	4,913	180,051	36.65	2
3	Registered Nurses	21,376	22,925	748,471	32.65	3
4	Licensed Practical Nurses	18,184	19,552	552,799	28.27	4
5	CNAs & Orderlies	67,655	73,252	1,149,282	15.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	8,960	9,923	145,941	14.71	9
10	Activity Assistants					10
11	Social Service Workers	2,507	2,614	61,263	23.44	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,737	17,036	233,330	13.70	15
16	Dishwashers					16
17	Maintenance Workers	2,012	2,212	33,391	15.10	17
18	Housekeepers	12,478	13,381	196,794	14.71	18
19	Laundry	4,107	4,351	51,823	11.91	19
20	Administrator	2,015	2,232	79,985	35.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,347	12,274	197,486	16.09	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	1,987	2,099	32,922	15.68	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Admissions Coord</u>	1,360	1,404	57,961	41.28	33
34	TOTAL (lines 1 - 33)	176,421	190,392	\$ 3,828,696 *	\$ 20.11	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	230	\$ 10,830	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	1,591	55,668	10-3	38
39	Pharmacist Consultant	262	13,122	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	29	1,453	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	133	8,269	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,245	\$ 89,342		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

Facility Name & ID Number Forest View Rehab & Nrsg Ctr

# 0051516

Report Period Beginning: 1/1/17

Ending: 12/31/17

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Margaux Dominguez	Administrator		\$ 79,985	Workers' Compensation Insurance	\$ 93,992	IDPH License Fee	\$	
				Unemployment Compensation Insurance	33,121	Advertising: Employee Recruitment		
				FICA Taxes	290,246	Health Care Worker Background Check		
				Employee Health Insurance	186,077	(Indicate # of checks performed )		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		IHCA	7,629	
				Pension	37,930	ILL Dept of Public Health	3,980	
				Uniforms	4,264	DuPage County Health Dept	1,015	
				Employee background checks	2,704	Village of Itasca	355	
				Employee expenses	10,257	Other dues and fees	1,771	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 79,985	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 658,591		\$ 14,750		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Mileage	1,827
							Auto Allowance	3,621
							Seminar Expense	
							Education and seminars	2,807
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 8,255	
C. Professional Services								
Vendor/Payee	Type		Amount					
Bradley Associates	Accounting		\$ 10,692					
Johnson, Goldburg	Accounting		2,900					
Other accounting	Accounting		4,686					
Infinity Healthcare	Prof/Mgmt Fees		277,135					
Empire Risk	Prof/Mgmt Fees		12,000					
Healthcare Recruiting Specialists	Prof/Mgmt Fees		10,608					
MTS Consulting	Prof/Mgmt Fees		5,124					
Stern Process & Investigations	Prof/Mgmt Fees		100					
Misc Legal	Legal		1,318					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 324,563					

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name &amp; ID Number Forest View Rehab &amp; Nrsg Ctr

# 0051516

Report Period Beginning:

1/1/17

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. Illinois Council - \$7,629
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 66,080 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 310,670  
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: 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