FOR BHF USE

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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

I. IDPH License ID Number: 0051516

Facility Name: Forest View Rehab & Nrsg Ctr

Address: 535 South Elm (Number) Itasca (City) 60143 (Zip Code)

County: Dupage

Telephone Number: 708-449-1900 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: 6/1/11

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		x	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Alan Sorscher **Telephone Number:** 708-449-1900
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/13 to 12/31/13 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name) Alan Sorscher
(Title) CFO

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/13 Ending: 12/31/13

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	24,472	2,986	3,870	31,328	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,472	2,986	3,870	31,328	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.60%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

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

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

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

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

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 14 and days of care provided 3,835

Medicare Intermediary NationalGovernment Srevices

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/13 Ending: 12/31/13

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	193,881	17,484	8,343	219,708		219,708	212	219,920			1
2	Food Purchase		169,660		169,660		169,660	90	169,750			2
3	Housekeeping	120,494	22,988		143,482		143,482		143,482			3
4	Laundry		14,033		14,033		14,033		14,033			4
5	Heat and Other Utilities			201,415	201,415		201,415	1,331	202,746			5
6	Maintenance	59,828	22,589	66,531	148,948		148,948	3,899	152,847			6
7	Other (specify):*											7
8	TOTAL General Services	374,203	246,754	276,289	897,246		897,246	5,532	902,778			8
	B. Health Care and Programs											
9	Medical Director			18,200	18,200		18,200		18,200			9
10	Nursing and Medical Records	2,369,285	328,688	29,753	2,727,726		2,727,726	5,137	2,732,863			10
10a	Therapy			469,510	469,510		469,510		469,510			10a
11	Activities	101,241	19,919		121,160		121,160		121,160			11
12	Social Services	52,985		2,520	55,505		55,505		55,505			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacy Consultant			9,297	9,297		9,297		9,297			15
16	TOTAL Health Care and Programs	2,523,511	348,607	529,280	3,401,398		3,401,398	5,137	3,406,535			16
	C. General Administration											
17	Administrative	90,395			90,395		90,395		90,395			17
18	Directors Fees											18
19	Professional Services			278,390	278,390		278,390	(184,868)	93,522			19
20	Dues, Fees, Subscriptions & Promotions			110,900	110,900		110,900	(92,740)	18,160			20
21	Clerical & General Office Expenses	130,361	73,676	212,292	416,329		416,329	17,974	434,303			21
22	Employee Benefits & Payroll Taxes			504,387	504,387		504,387	22,129	526,516			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,578	10,578		10,578	2,735	13,313			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			104,509	104,509		104,509	438	104,947			26
27	Other (specify):*											27
28	TOTAL General Administration	220,756	73,676	1,221,056	1,515,488		1,515,488	(234,332)	1,281,156			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,118,470	669,037	2,026,625	5,814,132		5,814,132	(223,663)	5,590,469			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 View Rehab & Nrsg Ctr #0051516 Report Period Beginning: 1/1/13 Ending: 12/31/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			538,921	538,921		538,921	(309,202)	229,719			30
31	Amortization of Pre-Op. & Org.			57,853	57,853		57,853		57,853			31
32	Interest			510,562	510,562		510,562	(438)	510,124			32
33	Real Estate Taxes			5,900	5,900		5,900		5,900			33
34	Rent-Facility & Grounds			1,893,455	1,893,455		1,893,455	(1,885,918)	7,537			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			3,006,691	3,006,691		3,006,691	(2,195,558)	811,133			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		324,905		324,905		324,905		324,905			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			245,680	245,680		245,680		245,680			42
43	Other (specify):* **Bad Debt**			245,856	245,856		245,856	(245,856)				43
44	**TOTAL Special Cost Centers**		324,905	491,536	816,441		816,441	(245,856)	570,585			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,118,470	993,942	5,524,852	9,637,264		9,637,264	(2,665,077)	6,972,187			45

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

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/13 Ending: 12/31/13

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(309,202)	30		9
10	Interest and Other Investment Income	(26,131)	21		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(44)	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	(92,740)	20		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(245,856)	43		24
25	Fund Raising, Advertising and Promotional	(26,000)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,897,792)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,597,765)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(67,312)	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (67,312)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,665,077)		37

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

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

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

Forest View Rehab & Nrsg Ctr

ID# 0051516

Report Period Beginning: 1/1/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$	21	1
2	misc income	(4,337)	21	2
3	rent	(1,893,455)	34	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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19				19
20				20
21				21
22				22
23				23
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26				26
27				27
28				28
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30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,897,792)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Forest View Rehab & Nrsg Ctr **#** 0051516 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(44)	256	0	0	0	0	0	0	0	0	0	212	1
2	Food Purchase	0	90	0	0	0	0	0	0	0	0	0	90	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,331	0	0	0	0	0	0	0	0	0	1,331	5
6	Maintenance	0	3,899	0	0	0	0	0	0	0	0	0	3,899	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(44)	5,576	0	0	0	0	0	0	0	0	0	5,532	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	5,137	0	0	0	0	0	0	0	0	0	5,137	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	5,137	0	0	0	0	0	0	0	0	0	5,137	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(184,868)	0	0	0	0	0	0	0	0	0	(184,868)	19
20	Fees, Subscriptions & Promotions	(92,740)	0	0	0	0	0	0	0	0	0	0	(92,740)	20
21	Clerical & General Office Expenses	(56,468)	74,442	0	0	0	0	0	0	0	0	0	17,974	21
22	Employee Benefits & Payroll Taxes	0	22,129	0	0	0	0	0	0	0	0	0	22,129	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,735	0	0	0	0	0	0	0	0	0	2,735	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	438	0	0	0	0	0	0	0	0	0	438	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(149,208)	(85,124)	0	0	0	0	0	0	0	0	0	(234,332)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(149,252)	(74,411)	0	0	0	0	0	0	0	0	0	(223,663)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Forest View Rehab & Nrsg Ctr **#** 0051516 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(309,202)	0	0	0	0	0	0	0	0	0	0	(309,202)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	(438)	0	0	0	0	0	0	0	0	0	(438)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(1,893,455)	7,537	0	0	0	0	0	0	0	0	0	(1,885,918)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,202,657)	7,099	0	0	0	0	0	0	0	0	0	(2,195,558)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(245,856)	0	0	0	0	0	0	0	0	0	0	(245,856)	43
44	**TOTAL Special Cost Centers**	(245,856)	0	0	0	0	0	0	0	0	0	0	(245,856)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(2,597,765)	(67,312)	0	0	0	0	0	0	0	0	0	(2,665,077)	45

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/13 Ending: 12/31/13

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
Moishe Gubin	20%			Infinity Healthcare	Hillside, Il	Management Co
Michael Blisko	20%					
A & F Realty	20%					
Rosie Schwartz	20%					
Dave Schechter	20%					

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	maint	$	Infinity Healthcare Management		$ 3,899	$ 3,899	1
2	V	10	nursing	24,290	Infinity Healthcare Management		29,427	5,137	2
3	V	1	dietary	8,343	Infinity Healthcare Management		8,599	256	3
4	V	5	utilities		Infinity Healthcare Management		1,331	1,331	4
5	V	21	office expense	33,997	Infinity Healthcare Management		108,439	74,442	5
6	V	2	food	(90)	Infinity Healthcare Management			90	6
7	V	19	Prof svcs	185,810	Infinity Healthcare Management		942	(184,868)	7
8	V	22	employee expenses	930	Infinity Healthcare Management		23,059	22,129	8
9	V	24	auto/travel expense	68	Infinity Healthcare Management		2,803	2,735	9
10	V	26	insurance		Infinity Healthcare Management		438	438	10
11	V	34	rent		Infinity Healthcare Management		7,537	7,537	11
12	V	30	depreciation		Infinity Healthcare Management				12
13	V	32	interest	608	Infinity Healthcare Management		170	(438)	13
14	Total			$ 253,956			$ 186,644	$ * (67,312)	14

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

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/13 Ending: 12/31/13

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
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28								28
29								29
30								30

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/13 Ending: 12/31/13

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: 1/1/13 Ending: 12/31/13

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 [X]

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

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/13 Ending: 12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HUD		x	Facility and property	$28,430.00	3/1/05	$ 4,722,000	$ 4,582,059	3/1/40	5.8300	$ 112,124	1
2	Seller Note 1		x	Facility and property	$12,000.00	11/1/13	1,528,026	1,528,026	11/1/18	3.6250	0	2
3	Seller Note 2		x	Facility and property	$12,000.00	11/1/13	526,997	526,997	11/1/18	3.6500	0	3
4												4
5												5
	Working Capital											
6	Infinity Funding	x		Working Capital	none	various	various	5,250,000	various	various	376,693	6
7	A & F Relaty		x	Working Capital	none	various	various		various	various	21,745	7
8												8
9	TOTAL Facility Related				$52,430.00		$ 6,777,023	$ 11,887,082			$ 510,562	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,777,023	$ 11,887,082			$ 510,562	15

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

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

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

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ (28,997)	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.)		$ 63,538	2
3. Under or (over) accrual (line 2 minus line 1).		$ 92,535	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ (86,635)	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 5,900	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2008		8
2009		9
2010	69,593	10
2011	77,529	11
2012	63,538	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2012 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

TELEPHONE 708-449-1900 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-17-102-040	Nursing Facility	$ 2,301.40	$ 2,301.40
2.	03-17-102-041	Nursing Facility	$ 30,178.02	$ 30,178.02
3.	03-17-102-045	Nursing Facility	$ 31,058.70	$ 31,058.70
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 63,538.12	$ 63,538.12

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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: 1/1/13 Ending: 12/31/13

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 [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	144		2013		$ 1,900,000	$ 5,556	39	$ 5,556	$	$ 5,556	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Install Metal Sheet Inside Roof			2011	1,402	36	39	36		93	9
10	Painting and Drywall			2011	2,559	66	39	66		170	10
11	Install TV Jacks in Every Room			2011	9,200	236	39	236		610	11
12	Install Sprinkler Head in Elevator Shaft			2011	1,485	38	39	38		98	12
13	Build & Install Exterior Sign			2011	6,435	165	39	165		426	13
14	Remove Old Fans and Paint Walls			2011	1,100	28	39	28		73	14
15											15
16	Remove and Replace Fire Sprinklers			2012	9,683	248	39	248		497	16
17	Remodel Resident Bathrooms			2012	12,905	331	39	331		662	17
18	Remodel Dining Room			2012	4,085	105	39	105		209	18
19	New phones and wiring			2012	9,544	245	39	245		489	19
20	Install new TV jacks			2012	3,750	96	39	96		192	20
21	Install exhaust fans in bathrooms			2012	1,950	50	39	50		100	21
22	Install new outlets throughout bedrooms			2012	9,980	256	39	256		512	22
23	Remodel lobby, vestibule, hallway, etc.			2012	226,000	5,795	39	5,795		11,589	23
24	Install fire dampers in exhaust fans			2012	40,423	1,036	39	1,036		2,073	24
25	Connect electricity for sign light			2012	2,043	52	39	52		105	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	
37	Claudiu Stoica	2/15/2013	$ 2,725	$ 35	39	$ 70	$ 35	$ 35	37
38	Claudiu Stoica	1/19/2013	650	8	39	17	9	8	38
39	Claudiu Stoica	3/1/2013	300	4	39	8	4	4	39
40	HD Supply	11/18/2013	3,455	44	39	89	45	44	40
41	Champion Roofing	4/2/2013	2,900	37	39	74	37	37	41
42	Adig Construction	1/4/2013	9,650	123	39	247	124	123	42
43	Integra	2/20/2013	2,400	31	39	62	31	31	43
44	Integra	5/29/2013	3,100	40	39	79	39	40	44
45	Integra	12/3/2012	5,500	71	39	141	70	71	45
46	Integra	5/29/2013	1,300	17	39	33	16	17	46
47	Integra	5/29/2013	4,000	51	39	103	52	51	47
48	Protective Fire	3/19/2013	8,994	115	39	231	116	115	48
49	Precision Heating	1/18/2013	2,467	32	39	63	31	32	49
50	Medallion Services	11/26/2012	1,097	14	39	28	14	14	50
51	Qualified Landscaping	7/10/2013	2,550	33	39	65	32	33	51
52	Solomon Plumbing	7/9/2013	1,500	19	39	38	19	19	52
53	Chicago Pro	11/22/2013	2,379	31	39	61	30	31	53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,297,512	$ 15,044		$ 15,748	$ 704	$ 24,159	70

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

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/13 Ending: 12/31/13

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	$ 111,190	$ 9,466	$ 22,238	$ 12,772	5/7	$ 77,445	71
72	Current Year Purchases	958,666	514,411	191,733	(322,678)	5	514,411	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,069,856	$ 523,877	$ 213,971	$ (309,906)		$ 591,856	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)	$ 3,367,368	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 538,921	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 229,719	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (309,202)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 616,015	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: 1/1/13 Ending: 12/31/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Itasca Shelter Care, LLC
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. [x] 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:		144	6/1/11	$ 513,455	20		3
4	Additions							4
5								5
6								6
7	TOTAL		144		$ 513,455 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning 6/1/11
    Ending 10/31/13

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2014	$
13.	/2015	$
14.	/2016	$

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

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

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/13 Ending: 12/31/13

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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.

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$		$ 255,140	$		$ 255,140	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			73,164			73,164	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			141,206			141,206	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				291,427		291,427	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): lab & radiology,ambua	39-2					33,478		33,478	13
14	TOTAL			$		$ 469,510	$ 324,905		$ 794,415	14

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

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 6,049	$ 14,646	1
2	Cash-Patient Deposits	(16,483)	(16,483)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,840,165	1,840,165	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	200,277	200,277	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,030,008	$ 2,038,605	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		1,300,000	14
15	Leasehold Improvements, at Historical Cost	397,512	397,512	15
16	Equipment, at Historical Cost	169,857	1,069,857	16
17	Accumulated Depreciation (book methods)	(128,315)	(616,015)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		5,206,743	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(57,853)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		321,901	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 439,054	$ 7,722,145	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,469,062	$ 9,760,750	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 634,018	$ 646,266	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	645,431	645,431	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	working capital	5,250,000	5,250,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,529,449	$ 6,541,697	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,637,081	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 6,637,081	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,529,449	$ 13,178,778	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,060,387)	$ (3,418,028)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,469,062	$ 9,760,750	48

***(See instructions.)**

Facility Name & ID Number Forest View Rehab & Nrsg Ctr **#** 0051516 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,872,538)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,872,538)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,196,220)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Related Party Property Co. net income**	8,371	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (2,187,849)	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)**	$ (4,060,387)	24 *

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

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/13 Ending: 12/31/13

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,862,960	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,862,960	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	167,616	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 167,616	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***	26,131	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 26,131	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Related Party Property Co. Income	1,380,000	28
28a	Misc Income	4,337	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,384,337	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,441,044	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	897,246	31
32	Health Care	3,401,398	32
33	General Administration	1,515,488	33
	B. Capital Expense		
34	Ownership	3,006,691	34
	C. Ancillary Expense		
35	Special Cost Centers	324,905	35
36	Provider Participation Fee	245,680	36
	D. Other Expenses (specify):		
37		245,856	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,637,264	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,196,220)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,196,220)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,908,859	44
45	Private Pay - Net Inpatient Revenue	809,036	45
46	Medicare - Net Inpatient Revenue	1,934,362	46
47	Other-(specify) Commercial Net Inpatient Revenue	210,703	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,862,960	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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: 1/1/13 Ending: 12/31/13

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,912	2,095	$ 88,760	$ 42.37	1
2	Assistant Director of Nursing	1,256	1,291	49,434	38.29	2
3	Registered Nurses	14,129	15,587	449,543	28.84	3
4	Licensed Practical Nurses	25,565	27,161	703,571	25.90	4
5	CNAs & Orderlies	58,062	67,857	887,968	13.09	5
6	CNA Trainees					6
7	Licensed Therapist	7,175	7,685	190,009	24.72	7
8	Rehab/Therapy Aides					8
9	Activity Director	7,498	8,263	101,241	12.25	9
10	Activity Assistants					10
11	Social Service Workers	2,008	2,272	52,985	23.32	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,125	17,188	193,881	11.28	15
16	Dishwashers					16
17	Maintenance Workers	4,098	4,296	59,828	13.93	17
18	Housekeepers	11,171	12,003	120,494	10.04	18
19	Laundry					19
20	Administrator	1,960	2,145	90,395	42.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,281	7,787	100,349	12.89	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,004	2,064	30,012	14.54	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	160,244	177,694	$ 3,118,470 *	$ 17.55	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	167	$ 8,343	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	595	29,753	10-3	38
39	Pharmacist Consultant	186	9,297	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	50	2,520	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	998	$ 49,913		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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: 1/1/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
joseph javier	admin		$ 33,770
adam zanger	admin		56,625
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 90,395

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
johnson goldberg & brown	accounting	$ 2,500
infinity healthcare	prof fees	185,163
bradley & associates	accounting	12,395
polsinelli	legal	2,586
life safety resources	prof fees	6,977
stirs	prof fees	47,500
medical expert	prof fees	1,314
various	legal	14,830
various	prof fees	5,125
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 278,390

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 53,752
Unemployment Compensation Insurance	51,093
FICA Taxes	253,093
Employee Health Insurance	106,133
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
uniforms	1,358
pension	9,706
employee exp	51,381
TOTAL (agree to Schedule V, line 22, col.8)	$ 526,516

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
illinois council	13,255
dupage county health	850
village of itasca	1,010
sec of state	250
various	805
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,160

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
mileage	1,531
autom allownace	10,882
Seminar Expense	
seminar	850
education	50
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,313

**See instructions.

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/13 Ending: 12/31/13

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

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

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **no**
If YES, give association name and amount. **n/a**

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity? **n/a**

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **37,216** 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? **x** YES ____ 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. $ **245,680**
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? ____
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 out of Schedule V? **n/a**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.