FOR BHF USE

LL1

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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0051516

Facility Name: Forest View Rehab & Nursing Ctr

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

County: Dupage

Telephone Number: (708) 449-1900 **Fax #** (708) 449-1500

HFS ID Number:

Date of Initial License for Current Owners: 06/01/11

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: Daniel S. Gaafar **Telephone Number:** (317) 237-5500
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 1/1/18 to 12/31/18 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) Paresh Vipani
(Title) CFO

Paid Preparer

(Signed) (Date)
(Print Name and Title) Daniel S. Gaafar, Partner
(Firm Name & Address) Bradley Associates, 201 S. Capitol Ave., Suite 700, Indianapolis, IN 46225
(Telephone) (317) 237-5500 Fax # (317) 237-5503

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 & Nursing Ctr # 0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	18,279	1,173	3,823	23,274	8
9	SNF/PED					9
10	ICF	16,354	1,049	1,411	18,815	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,633	2,222	5,234	42,089	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.08%

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 [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 6/1/11 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 2,247

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/18 Fiscal Year: 12/31/18

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

Facility Name & ID Number Forest View Rehab & Nursing Ctr # 0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	261,751	25,369	9,024	296,144		296,144	(62)	296,082			1
2	Food Purchase		251,855		251,855		251,855	1,144	252,999			2
3	Housekeeping	215,257	21,787		237,044		237,044	12	237,056			3
4	Laundry	57,994	14,225		72,219		72,219		72,219			4
5	Heat and Other Utilities			376,540	376,540		376,540	1,891	378,431			5
6	Maintenance	33,252	22,179	63,664	119,095		119,095	1,037	120,132			6
7	Other (specify):*											7
8	TOTAL General Services	568,254	335,415	449,228	1,352,897		1,352,897	4,022	1,356,919			8
	B. Health Care and Programs											
9	Medical Director			31,500	31,500		31,500		31,500			9
10	Nursing and Medical Records	3,002,187	173,423	55,668	3,231,278		3,231,278	(17,464)	3,213,814			10
10a	Therapy			625,245	625,245		625,245		625,245			10a
11	Activities	174,628	11,834		186,462		186,462		186,462			11
12	Social Services	80,471		6,360	86,831		86,831		86,831			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacy Consult			12,501	12,501		12,501	(280)	12,221			15
16	TOTAL Health Care and Programs	3,257,286	185,257	731,274	4,173,817		4,173,817	(17,744)	4,156,073			16
	C. General Administration											
17	Administrative	90,556			90,556		90,556		90,556			17
18	Directors Fees											18
19	Professional Services			369,605	369,605		369,605	(311,693)	57,912			19
20	Dues, Fees, Subscriptions & Promotions			2,765	2,765		2,765	(755)	2,010			20
21	Clerical & General Office Expenses	129,514	63,107	223,355	415,976		415,976	64,123	480,099			21
22	Employee Benefits & Payroll Taxes			736,426	736,426		736,426	27,588	764,014			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,815	6,815		6,815	267	7,082			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			173,001	173,001		173,001	27,968	200,969			26
27	Other (specify):*											27
28	TOTAL General Administration	220,070	63,107	1,511,967	1,795,144		1,795,144	(192,502)	1,602,642			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,045,610	583,779	2,692,469	7,321,858		7,321,858	(206,224)	7,115,634			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 & Nursing Ctr #0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			37,172	37,172		37,172	278,078	315,250			30
31	Amortization of Pre-Op. & Org.							229,963	229,963			31
32	Interest			747,016	747,016		747,016	179,072	926,088			32
33	Real Estate Taxes			72,221	72,221		72,221		72,221			33
34	Rent-Facility & Grounds			1,161,486	1,161,486		1,161,486	(1,157,743)	3,743			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,017,895	2,017,895		2,017,895	(470,630)	1,547,265			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			9,691	9,691		9,691		9,691			38
39	Ancillary Service Centers		109,168		109,168		109,168	(2,127)	107,041			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			318,431	318,431		318,431		318,431			42
43	Other (specify):* **Bad Debt Exp**			112,244	112,244		112,244	(112,244)				43
44	**TOTAL Special Cost Centers**		109,168	440,366	549,534		549,534	(114,371)	435,163			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,045,610	692,947	5,150,730	9,889,287		9,889,287	(791,225)	9,098,062			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 & Nursing Ctr # 0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 Reference	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	233,156	30		9
10	Interest and Other Investment Income	(3,783)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(62)	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				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	(112,244)	43		24
25	Fund Raising, Advertising and Promotional	(23,572)	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	(4,454)	various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 89,041		$	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)	(880,266)	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (880,266)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (791,225)		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 & Nursing Ctr

ID# 0051516

Report Period Beginning: 1/1/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc Income	$ (1,425)	10	1
2	Misc Income	(305)	21	2
3	Collection Costs	(165)	21	3
4	PAC Expense	(86)	20	4
5	RP Profit	(66)	10	5
6	RP Profit	(280)	15	6
7	RP Profit	(2,127)	39	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(4,454)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Forest View Rehab & Nursing Ctr # 0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	(62)	0	0	0	0	0	0	0	0	0	0	(62)	1
2	Food Purchase	0	1,144	0	0	0	0	0	0	0	0	0	1,144	2
3	Housekeeping	0	12	0	0	0	0	0	0	0	0	0	12	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,891	0	0	0	0	0	0	0	0	0	1,891	5
6	Maintenance	0	1,037	0	0	0	0	0	0	0	0	0	1,037	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(62)	4,084	0	0	0	0	0	0	0	0	0	4,022	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	(1,491)	(15,973)	0	0	0	0	0	0	0	0	0	(17,464)	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):*	(280)	0	0	0	0	0	0	0	0	0	0	(280)	15
16	**TOTAL Health Care and Programs**	(1,771)	(15,973)	0	0	0	0	0	0	0	0	0	(17,744)	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	(316,597)	4,904	0	0	0	0	0	0	0	0	(311,693)	19
20	Fees, Subscriptions & Promotions	(86)	(669)	0	0	0	0	0	0	0	0	0	(755)	20
21	Clerical & General Office Expenses	(24,042)	88,037	128	0	0	0	0	0	0	0	0	64,123	21
22	Employee Benefits & Payroll Taxes	0	27,588	0	0	0	0	0	0	0	0	0	27,588	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	267	0	0	0	0	0	0	0	0	0	267	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	1,009	26,959	0	0	0	0	0	0	0	0	27,968	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(24,128)	(200,365)	31,991	0	0	0	0	0	0	0	0	(192,502)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(25,961)	(212,254)	31,991	0	0	0	0	0	0	0	0	(206,224)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Forest View Rehab & Nursing Ctr # 0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	233,156	0	44,922	0	0	0	0	0	0	0	0	278,078	30
31	Amortization of Pre-Op. & Org.	0	0	229,963	0	0	0	0	0	0	0	0	229,963	31
32	Interest	(3,783)	0	182,855	0	0	0	0	0	0	0	0	179,072	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(1,157,743)	0	0	0	0	0	0	0	0	(1,157,743)	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	229,373	0	(700,003)	0	0	0	0	0	0	0	0	(470,630)	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	(2,127)	0	0	0	0	0	0	0	0	0	0	(2,127)	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):*	(112,244)	0	0	0	0	0	0	0	0	0	0	(112,244)	43
44	TOTAL Special Cost Centers	(114,371)	0	0	0	0	0	0	0	0	0	0	(114,371)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	89,041	(212,254)	(668,012)	0	0	0	0	0	0	0	0	(791,225)	45

Facility Name & ID Number Forest View Rehab & Nursing Ctr # 0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

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. [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	1	Dietary	$	Infinity Healthcare Management of Illinois		$	$	1
2	V	2	Food Purchases		Infinity Healthcare Management of Illinois		1,144	1,144	2
3	V	3	Housekeeping		Infinity Healthcare Management of Illinois		12	12	3
4	V	5	Utilities		Infinity Healthcare Management of Illinois		1,891	1,891	4
5	V	6	Maintenance		Infinity Healthcare Management of Illinois		1,037	1,037	5
6	V	10	Nursing	51,098	Infinity Healthcare Management of Illinois		35,125	(15,973)	6
7	V	19	Professional Fees	318,200	Infinity Healthcare Management of Illinois		1,603	(316,597)	7
8	V	20	Dues & Fees	780	Infinity Healthcare Management of Illinois		111	(669)	8
9	V	21	Office Expense	107,931	Infinity Healthcare Management of Illinois		195,968	88,037	9
10	V	22	Employee Benefits	2,243	Infinity Healthcare Management of Illinois		29,831	27,588	10
11	V	24	Travel Expense	3,281	Infinity Healthcare Management of Illinois		3,548	267	11
12	V	26	Insurance		Infinity Healthcare Management of Illinois		1,009	1,009	12
13	V	30	Depreciation		Infinity Healthcare Management of Illinois				13
14	Total			$ 483,533			$ 271,279	$ * (212,254)	14

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

Facility Name & ID Number Forest View Rehab & Nursing Ctr # 0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

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. [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)	
15	V	32	Interest	$	Infinity Healthcare Management		$ 3,270	$ 3,270	15
16	V	34	Rent		Infinity Healthcare Management		3,743	3,743	16
17	V								17
18	V	19	Professional Fees		Forest View Nursing Realty, LLC		4,904	4,904	18
19	V	21	Office Expense		Forest View Nursing Realty, LLC		128	128	19
20	V	26	Insurance		Forest View Nursing Realty, LLC		26,959	26,959	20
21	V	30	Depreciation		Forest View Nursing Realty, LLC		44,922	44,922	21
22	V	31	Amortization		Forest View Nursing Realty, LLC		229,963	229,963	22
23	V	32	Interest		Forest View Nursing Realty, LLC		179,585	179,585	23
24	V	33	Property Tax		Forest View Nursing Realty, LLC				24
25	V	34	Rent	1,161,486	Forest View Nursing Realty, LLC			(1,161,486)	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			$ 1,161,486			$ 493,474	$ * (668,012)	39

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

Facility Name & ID Number Forest View Rehab & Nursing Ctr # 0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	Bloomingdale				6
7			Landmark of Des Plaines Rehab Center	Des Plaines				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 & Nursing Ctr # 0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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 & Nursing Ctr # 0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 & Nursing Ctr # 0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 Loan		X	Mortgage	$21,777.00	6/26/14	$ 5,089,300	$ 4,751,325	6/1/49	3.7500	$ 179,585	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Capital One		X	Working Capital	None	Various	Various	7,267,687	None	Various	136,991	6
7	Infinity Funding	X		Working Capital	None	Various	Various	8,631	None	Various	613,295	7
8												8
9	TOTAL Facility Related				$21,777.00		$ 5,089,300	$ 12,027,643			$ 929,871	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,089,300	$ 12,027,643			$ 929,871	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 26,959 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.)

Facility Name & ID Number Forest View Rehab & Nursing Ctr # 0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ (79,318)	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.)		$ 70,543	2
3. Under or (over) accrual (line 2 minus line 1).		$ 149,861	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ (77,640)	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.		$ 72,221	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	62,180	8
	2014	62,431	9
	2015	70,117	10
	2016	70,415	11
	2017	70,543	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Forest View Rehab & Nursing 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 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-17-102-040	Nursing Facility	$ 2,474.02	$ 2,474.02
2.	03-17-102-041	Nursing Facility	$ 33,560.98	$ 33,560.98
3.	03-17-102-045	Nursing Facility	$ 34,508.26	$ 34,508.26
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 70,543.26	$ 70,543.26

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 & Nursing Ctr # 0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	Land		2013	$ 27,060	1
2	Land		2015	478,290	2
3	TOTALS			$ 505,350	3

Facility Name & ID Number Forest View Rehab & Nursing Ctr # 0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

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		$ 1,300,000	$ 33,333	39	$ 33,333	$	$ 154,391	4
5			2015		451,940	11,588	39	11,588		40,157	5
6			2013		4,400,420		39				6
7			2015		(451,940)						7
8											8
	Improvement Type**										
9	Install Metal Sheet Inside Roof			2011	1,402	36	39	36		273	9
10	Painting and Drywall			2011	2,559	66	39	66		499	10
11	Install TV Jacks in Every Room			2011	18,744	481	39	481		3,503	11
12	Install Sprinkler Head in Elevator Shaft			2011	1,485	38	39	38		289	12
13	Build & Install Exterior Sign			2011	6,435	165	39	165		1,252	13
14	Remove Old Fans and Paint Walls			2011	1,100	28	39	28		213	14
15											15
16	Remove and Replace Fire Sprinklers			2012	9,683	248	39	248		1,737	16
17	Remodel Resident Bathrooms			2012	12,905	331	39	331		2,317	17
18	Remodel Dining Room			2012	4,085	105	39	105		734	18
19	New phones and wiring			2012							19
20	Install new TV jacks			2012	3,750	96	39	96		672	20
21	Install exhaust fans in bathrooms			2012	1,950	50	39	50		350	21
22	Install new outlets throughout bedrooms			2012	9,980	256	39	256		1,792	22
23	Remodel lobby, vestibule, hallway, etc.			2012	226,000	5,795	39	5,795		40,563	23
24	Install fire dampers in exhaust fans			2012	40,423	1,036	39	1,036		7,253	24
25	Connect electricity for sign light			2012	2,043	52	39	52		365	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 & Nursing Ctr # 0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	Painting on 1st floor resident rooms	2013	$ 2,725	$ 70	39	$ 70	$	$ 385	37
38	Tub removal, new tiles on 1st floor	2013	650	17	39	17		93	38
39	Install cove base on 1st floor	2013	300	8	39	8		44	39
40	Water Heater	2013	3,455	89	39	89		489	40
41	Roof work due to leak	2013	2,900	74	39	74		408	41
42	Modify emergency panel for 2 phase 120/208 service & transforme	2013	9,650	247	39	247		1,359	42
43	Johnsite sihouette Base, light Oak Wall Art rubber wall base	2013	2,400	62	39	62		340	43
44	Plumbing, lights, cove base, paint, ceiling tiles in copy room	2013	3,100	79	39	79		435	44
45	Flooring and cove base in 5 resident rooms	2012	12,100	310	39	310		1,621	45
46	Lighting in vestibule, chrome grids for elevator, signage	2013	1,300	33	39	33		182	46
47	Waste line, electrical in ceiling and A/C work in Lobby	2013	4,000	103	39	103		566	47
48	Sprinker work, pipe inspection, relocate sprinkler heads	2013	8,994	231	39	231		1,269	48
49	Pump motor and bearings in water heater boiler.	2013	2,467	63	39	63		347	49
50	Cubicle curtains	2013	1,097	28	39	28		154	50
51	Replace asphalt	2013	2,550	65	39	65		358	51
52	Open wall, replace pips on 1st floor	2013	1,500	38	39	38		210	52
53	Opened 40'x16' roof area and sealed	2013	2,379	61	39	61		336	53
54									54
55	Chicago Pro - stell exterior door	2014	13,999	359	39	359		1,795	55
56	Hinsdale Tile & Carpet - 3rd floor corridors tile	2014	4,874	125	39	125		625	56
57	Superior Construction - replace 2nd floor hallway carpet	2014			39				57
58	Cybor Fire - fire sprinklers	2014	2,891	74	39	74		370	58
59	Superior Construction - replace 2nd floor hallway carpet	2014	4,990	128	39	128		640	59
60	C.S.R. - patch cracks on main driveway	2014	2,100	54	39	54		270	60
61	Greenview Construction - replace masonry walls & doors	2014	4,217	108	39	108		540	61
62	Suburban Elevator - furnishh & instill door restrictors	2014	2,980	76	39	76		380	62
63	Valley Fire Protection - replace pipes with cast iron	2014	4,700	121	39	121		605	63
64	Valley Fire Protection - gas water heaters	2014	13,000	333	39	333		1,665	64
65	Precision Heating - generator room duct work	2014	2,265	58	39	58		290	65
66	Superior Construction - replace tiles & open kitchen wall	2014	4,512	116	39	116		580	66
67	Precision Heating - air louver for heating boilers	2014	3,855	99	39	99		495	67
68	Cary Supply - new wander system	2014	3,467	89	39	89		445	68
69	Replace bedroom floor tile	2014			39				69
70	TOTAL (lines 4 thru 69)		$ 6,172,382	$ 57,022		$ 57,022	$	$ 273,656	70

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

Facility Name & ID Number Forest View Rehab & Nursing Ctr # 0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,172,382	$ 57,022		$ 57,022	$	$ 273,656	1
2	Furnish and install one standard pit ladder per elevator	2015	3,900	100	39	100		300	2
3	Inspect and clean all fire dampers in the building	2015	2,758	71	39	71		284	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		332	5
6	Repair and repave parking lot	2015	39,000	1,000	39	1,000		4,000	6
7	Repair south canopy ceiling, brick, and metal drip edge	2015	3,950	101	39	101		404	7
8	Repair or replace damaged shingles	2015	3,950	101	39	101		404	8
9	Apply patch to the field/wall flashings (North & South sect.)	2015	6,021	155	39	154	(1)	620	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	14,392	14
15	Install new circuit breaker system	2015	14,100	362	39	362		1,448	15
16									16
17	Install dedicated generator line 2nd floor	2016	1,375	35	39	35		105	17
18	Replace therapy room windows	2016	5,000	128	39	128		384	18
19	Paint kitchen, therapy room, & day room	2016	2,550	65	39	65		195	19
20	Stain railings on entire 2nd floor	2016	1,980	51	39	51		153	20
21	Replace fire alarm system hardware	2016	5,900	151	39	151		453	21
22	Doors for 1st floor main entrance, 2nd floor N exit and hallway	2016	4,374	112	39	112		336	22
23	New facility surveillance cameras	2016	5,000	128	39	128		384	23
24	DISPOSAL - Pit ladders from FY 15	2016	(3,900)	(100)	39	(100)		(300)	24
25	DISPOSAL - Roof repair (repair south canopy ceiling) from FY 15	2016	(3,950)	(101)	39	(101)		(303)	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	84	39	83	(1)	127	28
29	Picture Windows for North & South sides of Building	2017	3,747	96	39	96		144	29
30	Life Safety Panels for North & South Building	2017	9,300	238	39	238		357	30
31	Door Wreck for elevator	2017	2,600	67	39	67		100	31
32	New Cylinder Elevator One	2017	27,500	705	39	705		1,058	32
33	Ceiling & Wall Speakers for Overhead Paging on 2nd Floor	2017	3,132	80	39	80		120	33
34	TOTAL (lines 1 thru 33)		$ 6,286,605	$ 64,332		$ 64,331	$ (1)	$ 299,153	34

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

Facility Name & ID Number Forest View Rehab & Nursing Ctr # 0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,286,605	$ 64,332		$ 64,331	$ (1)	$ 299,153	1
2									2
3	New flooring, walls, nurses station, etc for entire South Unit	2018	338,561	4,341	39	4,341		4,341	3
4	Replace oxygen room door on 1st floor	2018	2,503	32	39	32		32	4
5	Addition of locking mechanism to main entry door	2018	3,403	44	39	44		44	5
6	New air conditioners	2018	3,750	48	39	48		48	6
7	Instll new door hinges for rooms 243,246,247,248,249,251,252,253	2018	4,817	62	39	62		62	7
8	Replace 2nd floor baseboards	2018	6,639	85	39	85		85	8
9	New phone system for 2nd floor nurses station & therpay room	2018	4,561	58	39	58		58	9
10	5 new life safety doors on 2nd floor south	2018	7,132	91	39	91		91	10
11	Rebuild 2nd floor nurses call sytem	2018	6,241	80	39	80		80	11
12	New floor and signage for nurse's bathroom	2018	3,380	43	39	43		43	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,667,592	$ 69,216		$ 69,215	$ (1)	$ 304,037	34

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

Facility Name & ID Number Forest View Rehab & Nursing Ctr # 0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 1,204,985	$ 10,962	$ 240,997	$ 230,035	5-7	$ 1,192,605	71
72	Current Year Purchases	25,189	1,914	5,038	3,124	5	1,914	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,230,174	$ 12,876	$ 246,035	$ 233,159		$ 1,194,519	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)	$ 8,403,116	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 82,092	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 315,250	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 233,158	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,498,556	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 & Nursing Ctr # 0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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 ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

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 & Nursing Ctr # 0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 & Nursing Ctr # 0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	$	3,608	$ 243,399	$	3,608	$ 243,399	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		2,087	102,639		2,087	102,639	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		4,945	279,207		4,945	279,207	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				97,635		97,635	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray & Lab	39-2					11,533		11,533	12
13	Other (specify):									13
14	TOTAL			$	10,640	$ 625,245	$ 109,168	10,640	$ 734,413	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 & Nursing Ctr # 0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18 (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	$ (51,764)	$ (13,442)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,655,826	2,655,826	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	256,204	256,204	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Escrow Accounts		49,780	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,860,266	$ 2,948,368	10
	B. Long-Term Assets			
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	1,138,068	1,138,068	15
16	Equipment, at Historical Cost	330,176	1,230,176	16
17	Accumulated Depreciation (book methods)	(404,010)	(1,498,558)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	113,171	3,562,624	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(1,305,298)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Replacement reserves	179,088	498,736	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,356,493	$ 5,883,038	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,216,759	$ 8,831,406	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,003,400	$ 1,086,856	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,191	6,191	28
29	Short-Term Notes Payable		84,593	29
30	Accrued Salaries Payable	257,789	257,789	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,331	23,331	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		14,848	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Working Capital	7,267,687	7,267,687	36
37	Working Capital	8,631	8,631	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 8,567,029	$ 8,749,926	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		4,666,732	39
40	Mortgage Payable			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)**	$	$ 4,666,732	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,567,029	$ 13,416,658	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,350,270)	$ (4,585,252)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,216,759	$ 8,831,406	48

*(See instructions.)

Facility Name & ID Number Forest View Rehab & Nursing Ctr # 0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,654,195)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,654,195)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(696,075)	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)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (696,075)	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)**	$ (4,350,270)	24 *

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

Facility Name & ID Number Forest View Rehab & Nursing Ctr # 0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 7,934,444	1
2	Discounts and Allowances for all Levels	649,711	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,584,155	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	535,640	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 535,640	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	56,410	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,356	19
20	Radiology and X-Ray	2,890	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 67,656	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,091	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,091	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a	Misc Revenue	2,670	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,670	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,193,212	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,352,897	31
32	Health Care	4,173,817	32
33	General Administration	1,795,144	33
	B. Capital Expense		
34	Ownership	2,017,895	34
	C. Ancillary Expense		
35	Special Cost Centers	109,168	35
36	Provider Participation Fee	318,431	36
	D. Other Expenses (specify):		
37	Bad Debt Expense	112,244	37
38	Medically Necessary Transportation	9,691	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,889,287	40
41	**Income before Income Taxes (line 30 minus line 40)****	(696,075)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (696,075)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,370,862	44
45	Private Pay - Net Inpatient Revenue	509,550	45
46	Medicare - Net Inpatient Revenue	1,160,111	46
47	Other-(specify)	543,632	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,584,155	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 & Nursing Ctr # 0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	2,021	2,159	$ 110,138	$ 51.01	1
2	Assistant Director of Nursing	4,460	4,858	180,226	37.10	2
3	Registered Nurses	22,378	24,112	885,524	36.73	3
4	Licensed Practical Nurses	15,214	16,580	526,784	31.77	4
5	CNAs & Orderlies	61,536	67,440	1,200,807	17.81	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	10,385	11,225	174,628	15.56	9
10	Activity Assistants					10
11	Social Service Workers	3,009	3,184	80,471	25.27	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,195	17,666	261,751	14.82	15
16	Dishwashers					16
17	Maintenance Workers	1,973	2,166	33,252	15.35	17
18	Housekeepers	13,435	14,081	215,257	15.29	18
19	Laundry	3,494	4,129	57,994	14.05	19
20	Administrator	2,024	2,212	90,556	40.94	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,987	7,778	129,514	16.65	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	2,009	2,187	36,937	16.89	31
32	Other Health Care(specify)					32
33	Other(specify) Admissions Coord	1,726	1,920	61,771	32.17	33
34	TOTAL (lines 1 - 33)	166,846	181,697	$ 4,045,610 *	$ 22.27	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	192	$ 9,024	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	250	12,501	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	(440)	(22,000)	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	93	5,750	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,686	$ 60,943		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 & Nursing Ctr # 0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Margaux Dominguez	Administrator		$ 42,491
Allison Bertacchi	Administrator		48,065
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 90,556

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
Infinity Funding / Sedgwick	Legal	$ 22,754
Abbey Road Tax Consultants	Legal	602
Thomas Boundas & Assoc	Legal	1,904
Bradley Associates	Accounting	12,000
MTS Consulting	Prof/Mgmt Fees	(5,124)
Infinity Healthcare	Prof/Mgmt Fees	318,273
Capital One	Prof/Mgmt Fees	6,917
Misc Professional Fees	Prof/Mgmt Fees	1,104
Empire Risk	Prof/Mgmt Fees	11,175
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 369,605

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 157,232
Unemployment Compensation Insurance	15,853
FICA Taxes	314,984
Employee Health Insurance	213,756
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	38,063
Uniforms	3,874
Employee background checks	2,327
Employee expenses	17,925
TOTAL (agree to Schedule V, line 22, col.8)	$ 764,014

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
IHCA	1,274
Dupage County Health Dept	830
Secretary of State	277
Infinity	(371)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,010

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Auto Allowance	267
Mileage	5,303
Seminar Expense	
Education & Seminars	1,512
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,082

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Forest View Rehab & Nursing Ctr # 0051516 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 - $1,188**

(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. $ **66,314** 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. $ **318,431**
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