FOR BHF USE

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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 #** 708-449-1500

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	XX	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: Aaron Mauer **Telephone Number:** 773-747-4506
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 1/1/20 to 12/31/20 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) 3/5/2021 (Date)
(Print Name and Title) Aaron Mauer, President
(Firm Name & Address) GGM Associates, Inc., 6101 Nimtz Parkway South Bend IN 46628
(Telephone) 773-747-4506 Fax # 773-747-4725

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: 1/1/20 Ending: 12/31/20

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 NA

	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	15,615	1,184	8,066	24,865	8
9	SNF/PED					9
10	ICF	13,971	1,060	1,154	16,185	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,586	2,244	9,220	41,050	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.10%

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)
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 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 6,776

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	314,987	23,132	9,600	347,719		347,719	(74)	347,645			1
2	Food Purchase		286,156		286,156		286,156		286,156			2
3	Housekeeping	276,556	26,676		303,232		303,232		303,232			3
4	Laundry	41,378	12,740		54,118		54,118		54,118			4
5	Heat and Other Utilities			244,888	244,888		244,888	1,728	246,616			5
6	Maintenance	62,129	21,838	62,469	146,436		146,436	26	146,462			6
7	Other (specify):*											7
8	TOTAL General Services	695,050	370,542	316,957	1,382,549		1,382,549	1,680	1,384,229			8
	B. Health Care and Programs											
9	Medical Director			39,500	39,500		39,500		39,500			9
10	Nursing and Medical Records	3,227,906	266,712	930,327	4,424,945		4,424,945	(165,324)	4,259,621			10
10a	Therapy			998,349	998,349		998,349		998,349			10a
11	Activities	152,223	8,936		161,159		161,159		161,159			11
12	Social Services	73,489		3,853	77,342		77,342		77,342			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultants			11,988	11,988		11,988	(289)	11,699			15
16	TOTAL Health Care and Programs	3,453,618	275,648	1,984,017	5,713,283		5,713,283	(165,613)	5,547,670			16
	C. General Administration											
17	Administrative	103,475		7,006	110,481		110,481	45,626	156,107			17
18	Directors Fees											18
19	Professional Services			807,397	807,397		807,397	(137,786)	669,611			19
20	Dues, Fees, Subscriptions & Promotions			3,985	3,985		3,985	123	4,108			20
21	Clerical & General Office Expenses	191,396	37,048	374,193	602,637		602,637	67,930	670,567			21
22	Employee Benefits & Payroll Taxes			743,686	743,686		743,686	34,514	778,200			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,660	10,660		10,660	8,211	18,871			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			797,426	797,426		797,426	27,439	824,865			26
27	Other (specify):*											27
28	TOTAL General Administration	294,871	37,048	2,744,353	3,076,272		3,076,272	46,056	3,122,328			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,443,539	683,238	5,045,327	10,172,104		10,172,104	(117,877)	10,054,227			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: 1/1/20 Ending: 12/31/20

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			54,500	54,500		54,500	89,973	144,473			30
31	Amortization of Pre-Op. & Org.			13,638	13,638		13,638	229,963	243,601			31
32	Interest			7,822	7,822		7,822	160,935	168,757			32
33	Real Estate Taxes			81,701	81,701		81,701		81,701			33
34	Rent-Facility & Grounds			1,232,220	1,232,220		1,232,220	(1,228,042)	4,178			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,389,881	1,389,881		1,389,881	(747,172)	642,709			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			11,678	11,678		11,678		11,678			38
39	Ancillary Service Centers		246,612		246,612		246,612	(5,039)	241,573			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			282,299	282,299		282,299		282,299			42
43	Other (specify):*			219,728	219,728		219,728	(219,728)				43
44	**TOTAL Special Cost Centers**		246,612	513,705	760,317		760,317	(224,767)	535,550			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,443,539	929,850	6,948,913	12,322,302		12,322,302	(1,089,816)	11,232,486			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: 1/1/20 Ending: 12/31/20

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	44,996	30		9
10	Interest and Other Investment Income	(7,455)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(74)	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	(1,440)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(219,728)	43		24
25	Fund Raising, Advertising and Promotional	(6,215)	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	(6,664)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (196,580)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (893,236)	Various	36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,089,816)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Forest View Rehab & Nrsg Ctr

ID# 0051516

Report Period Beginning: 1/1/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	RP Profit	$ (134)	10	1
2	RP Profit	(289)	15	2
3	RP Profit	(5,039)	39	3
4	Misc Income - Vendor Rebate	(958)	6	4
5	Misc Income - Med Records	(245)	10	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
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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**	(6,664)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(74)	0	0	0	0	0	0	0	0	0	0	(74)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,728	0	0	0	0	0	0	0	0	0	1,728	5
6	Maintenance	(958)	984	0	0	0	0	0	0	0	0	0	26	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,032)	2,712	0	0	0	0	0	0	0	0	0	1,680	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	(379)	(164,946)	0	0	0	0	0	0	0	0	0	(165,324)	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):*	(289)	0	0	0	0	0	0	0	0	0	0	(289)	15
16	TOTAL Health Care and Programs	(668)	(164,946)	0	0	0	0	0	0	0	0	0	(165,613)	16
	C. General Administration													
17	Administrative	0	45,626	0	0	0	0	0	0	0	0	0	45,626	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(116,954)	(20,832)	0	0	0	0	0	0	0	0	(137,786)	19
20	Fees, Subscriptions & Promotions	0	123	0	0	0	0	0	0	0	0	0	123	20
21	Clerical & General Office Expenses	(7,655)	75,585	0	0	0	0	0	0	0	0	0	67,930	21
22	Employee Benefits & Payroll Taxes	0	34,514	0	0	0	0	0	0	0	0	0	34,514	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	8,211	0	0	0	0	0	0	0	0	0	8,211	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	1,832	25,607	0	0	0	0	0	0	0	0	27,439	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(7,655)	48,936	4,775	0	0	0	0	0	0	0	0	46,056	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(9,354)	(113,298)	4,775	0	0	0	0	0	0	0	0	(117,877)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	44,996	55	44,922	0	0	0	0	0	0	0	0	89,973	30
31	Amortization of Pre-Op. & Org.	0	0	229,963	0	0	0	0	0	0	0	0	229,963	31
32	Interest	(7,455)	4,602	163,788	0	0	0	0	0	0	0	0	160,935	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	4,178	(1,232,220)	0	0	0	0	0	0	0	0	(1,228,042)	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	37,541	8,834	(793,547)	0	0	0	0	0	0	0	0	(747,172)	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	(5,039)	0	0	0	0	0	0	0	0	0	0	(5,039)	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):*	(219,728)	0	0	0	0	0	0	0	0	0	0	(219,728)	43
44	TOTAL Special Cost Centers	(224,767)	0	0	0	0	0	0	0	0	0	0	(224,767)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(196,580)	(104,463)	(788,772)	0	0	0	0	0	0	0	0	(1,089,816)	45

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	50.00	Ambassador Nursing & Rehab Center	Chicago	Infinity Healthcare	Hillside	Consulting Co.
GELP	50.00	Belhaven Nursing & Rehab Center	Chicago	Forest View Realty		Realty Co.
		City View Multicare Center	Cicero			
		Continental Nursing & Rehab Center	Chicago			
		Lakeview Nursing & Rehab Center	Chicago			
		Midway Neurological & Rehab Center	Bridgeview			

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	5	Heat and Other Utilities	$	Infinity Healthcare Management of IL LLC		$ 1,728	$ 1,728	1
2	V	6	Maintenance		Infinity Healthcare Management of IL LLC		984	984	2
3	V	10	Nursing and Medical Records	215,415	Infinity Healthcare Management of IL LLC		50,469	(164,946)	3
4	V	17	Administrative	2,215	Infinity Healthcare Management of IL LLC		47,841	45,626	4
5	V	19	Professional Services	631,008	Infinity Healthcare Management of IL LLC		514,054	(116,954)	5
6	V	20	Dues, Fees, Subscriptions & Promotions		Infinity Healthcare Management of IL LLC		123	123	6
7	V	21	Clerical & General Office Expenses	100,906	Infinity Healthcare Management of IL LLC		176,491	75,585	7
8	V	22	Employee Benefits & Payroll Taxes	9	Infinity Healthcare Management of IL LLC		34,523	34,514	8
9	V	24	Travel and Seminar	3,639	Infinity Healthcare Management of IL LLC		11,850	8,211	9
10	V	26	Insurance-Prop.Liab.Malpractice		Infinity Healthcare Management of IL LLC		1,832	1,832	10
11	V	30	Depreciation		Infinity Healthcare Management of IL LLC		55	55	11
12	V	32	Interest		Infinity Healthcare Management of IL LLC		4,602	4,602	12
13	V	34	Rent-Facility & Grounds		Infinity Healthcare Management of IL LLC		4,178	4,178	13
14	Total			$ 953,192			$ 848,729	$ * (104,463)	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: 1/1/20 Ending: 12/31/20

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	34	Rent	$ 1,232,220	Forest View Nursing Realty, LLC		$	$ (1,232,220)	15
16	V	31	Amortization		Forest View Nursing Realty, LLC		229,963	229,963	16
17	V	30	Depreciation		Forest View Nursing Realty, LLC		44,922	44,922	17
18	V	19	Professional Services		Forest View Nursing Realty, LLC		(20,832)	(20,832)	18
19	V	26	Insurance		Forest View Nursing Realty, LLC		25,607	25,607	19
20	V	32	Interest		Forest View Nursing Realty, LLC		163,788	163,788	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,232,220			$ 443,448	$ * (788,772)	39

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

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/20 Ending: 12/31/20

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			Momence Meadows Nrusing & Rehab Ctr	Momence				1
2			Niles Nursing & Rehab Center	Niles				2
3			Oak Lawn Respiratory & Rehab Center	Oak Lawn				3
4			Parker Nursing & Rehab Center	Streater				4
5			Parkshore Estates Nursing & Rehab Ctr	Chicago				5
6			Southpoint Nursing & Rehab Center	Chicago				6
7			West Suburban Nursing & Rehab Center	Bloomington				7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/20 Ending: 12/31/20

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: 1/1/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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: 1/1/20 Ending: 12/31/20

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HUD		X	Mortgage	$21,160.00	6/26/14	$ 5,089,300	$ 4,583,197	6/1/49	3.5000	$ 165,004	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Credit Suisse		X	Working Capital	None	Various	Various	Various	3/14/2022	4.5000	10,147	6
7	Infintiy Funding	X		Working Capital	Various	Various	Various	127,070	None	Various		7
8												8
9	TOTAL Facility Related				$21,160.00		$ 5,089,300	$ 4,710,267			$ 175,151	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	$ 4,710,267			$ 175,151	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 25,607 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 & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ (75,381)	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.)		$ 92,099	2
3. Under or (over) accrual (line 2 minus line 1).		$ 167,480	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ (85,780)	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.		$ 81,701	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	70,117	8
	2016	70,415	9
	2017	70,543	10
	2018	73,668	11
	2019	92,099	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 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 Aaron Mauer

TELEPHONE 773-747-4506 FAX #: 773-747-4725

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-17-102-040	Nursing Home	$ 2,686.62	$ 2,686.62
2.	03-17-102-041	Nursing Home	$ 44,192.52	$ 44,192.52
3.	03-17-102-045	Nursing Home	$ 45,220.28	$ 45,220.28
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 92,099.42	$ 92,099.42

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 1/1/20 Ending: 12/31/20

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 & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$	$ 187,724	4
5			2015		451,940	11,588	39	11,588		51,745	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		345	9
10	Painting and Drywall			2011	2,559	66	39	66		630	10
11	Install TV Jacks in Every Room			2011	18,744	481	39	481		4,464	11
12	Install Sprinkler Head in Elevator Shaft			2011	1,485	38	39	38		365	12
13	Build & Install Exterior Sign			2011	6,435	165	39	165		1,582	13
14	Remove Old Fans and Paint Walls			2011	1,100	28	39	28		269	14
15											15
16	Remove and Replace Fire Sprinklers			2012	9,683	248	39	248		2,234	16
17	Remodel Resident Bathrooms			2012	12,905	331	39	331		2,979	17
18	Remodel Dining Room			2012	4,085	105	39	105		943	18
19	New phones and wiring			2012							19
20	Install new TV jacks			2012	3,750	96	39	96		864	20
21	Install exhaust fans in bathrooms			2012	1,950	50	39	50		450	21
22	Install new outlets throughout bedrooms			2012	9,980	256	39	256		2,304	22
23	Remodel lobby, vestibule, hallway, etc.			2012	226,000	5,795	39	5,795		52,153	23
24	Install fire dampers in exhaust fans			2012	40,423	1,036	39	1,036		9,326	24
25	Connect electricity for sign light			2012	2,043	52	39	52		470	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: 1/1/20 Ending: 12/31/20

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	$	$ 525	37
38	Tub removal, new tiles on 1st floor	2013	650	17	39	17		126	38
39	Install cove base on 1st floor	2013	300	8	39	8		59	39
40	Water Heater	2013	3,455	89	39	89		666	40
41	Roof work due to leak	2013	2,900	74	39	74		557	41
42	Modify emergency panel for 2 phase 120/208 service & transforme	2013	9,650	247	39	247		1,854	42
43	Johnsite sihouette Base, light Oak Wall Art rubber wall base	2013	2,400	62	39	62		463	43
44	Plumbing, lights, cove base, paint, ceiling tiles in copy room	2013	3,100	79	39	79		594	44
45	Flooring and cove base in 5 resident rooms	2013	12,100	310	39	310		2,242	45
46	Lighting in vestibule, chrome grids for elevator, signage	2013	1,300	33	39	33		249	46
47	Waste line, electrical in ceiling and A/C work in Lobby	2013	4,000	103	39	103		771	47
48	Sprinker work, pipe inspection, relocate sprinkler heads	2013	8,994	231	39	231		1,730	48
49	Pump motor and bearings in water heater boiler.	2013	2,467	63	39	63		474	49
50	Cubicle curtains	2013	1,097	28	39	28		210	50
51	Replace asphalt	2013	2,550	65	39	65		489	51
52	Open wall, replace pips on 1st floor	2013	1,500	38	39	38		287	52
53	Opened 40'x16' roof area and sealed	2013	2,379	61	39	61		458	53
54									54
55	Chicago Pro - stell exterior door	2014	13,999	359	39	359		2,513	55
56	Hinsdale Tile & Carpet - 3rd floor corridors tile	2014	4,874	125	39	125		875	56
57	Superior Construction - replace 2nd floor hallway carpet	2014							57
58	Cybor Fire - fire sprinklers	2014	2,891	74	39	74		518	58
59	Superior Construction - replace 2nd floor hallway carpet	2014	4,990	128	39	128		896	59
60	C.S.R. - patch cracks on main driveway	2014	2,100	54	39	54		378	60
61	Greenview Construction - replace masonry walls & doors	2014	4,217	108	39	108		756	61
62	Suburban Elevator - furnishh & instill door restrictors	2014	2,980	76	39	76		533	62
63	Valley Fire Protection - replace pipes with cast iron	2014	4,700	121	39	121		846	63
64	Valley Fire Protection - gas water heaters	2014	13,000	333	39	333		2,332	64
65	Precision Heating - generator room duct work	2014	2,265	58	39	58		406	65
66	Superior Construction - replace tiles & open kitchen wall	2014	4,512	116	39	116		811	66
67	Precision Heating - air louver for heating boilers	2014	3,855	99	39	99		693	67
68	Cary Supply - new wander system	2014	3,467	89	39	89		623	68
69	Replace bedroom floor tile	2014							69
70	TOTAL (lines 4 thru 69)		$ 6,172,381	$ 57,023		$ 57,023	$	$ 342,780	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: 1/1/20 Ending: 12/31/20

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		$ 6,172,381	$ 57,023		$ 57,023	$	$ 342,780	1
2	Furnish and install one standard pit ladder per elevator	2015	3,900	100	39	100		500	2
3	Inspect and clean all fire dampers in the building	2015	2,758	71	39	71		425	3
4	Apply patches to the north and south sections of the roof	2015							4
5	Paint rooms 134,137,147,149,150,152,237 & conf. rm	2015	3,250	83	39	83		499	5
6	Repair and repave parking lot	2015	39,000	1,000	39	1,000		6,000	6
7	Repair south canopy ceiling, brick, and metal drip edge	2015	3,950	101	39	101		607	7
8	Repair or replace damaged shingles	2015	3,950	101	39	101		607	8
9	Apply patch to the field/wall flashings (North & South sect.)	2015	6,021	154	39	154		929	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	3,599	39	3,599		21,589	14
15	Install new circuit breaker system	2015	14,100	362	39	362		2,171	15
16									16
17	Install dedicated generator line 2nd floor	2016	1,375	35	39	35		176	17
18	Replace therapy room windows	2016	5,000	128	39	128		640	18
19	Paint kitchen, therapy room, & day room	2016	2,550	65	39	65		326	19
20	Stain railings on entire 2nd floor	2016	1,980	51	39	51		255	20
21	Replace fire alarm system hardware	2016	5,900	151	39	151		756	21
22	Doors for 1st floor main entrance, 2nd floor N exit and hallway	2016	4,374	112	39	112		560	22
23	New facility surveillance cameras	2016	5,000	128	39	128		640	23
24	DISPOSAL - Pit ladders from FY 15	2016	(3,900)	(100)	39	(100)		(500)	24
25	DISPOSAL - Roof repair (repair south canopy ceiling) from FY 15	2016	(3,950)	(101)	39	(101)		(506)	25
26	IDPH Capital Report Adjustments 6/30/16	2016	(170,898)		39				26
27									27
28	B&G Replacement Pump Assembly for South End of Building	2017	3,237	83	39	83		293	28
29	Picture Windows for North & South sides of Building	2017	3,747	96	39	96		336	29
30	Life Safety Panels for North & South Building	2017	9,300	238	39	238		834	30
31	Door Wreck for elevator	2017	2,600	67	39	67		233	31
32	New Cylinder Elevator One	2017	27,500	705	39	705		2,468	32
33	Ceiling & Wall Speakers for Overhead Paging on 2nd Floor	2017	3,132	80	39	80		281	33
34	TOTAL (lines 1 thru 33)		$ 6,286,604	$ 64,333		$ 64,333	$	$ 382,899	34

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

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/20 Ending: 12/31/20

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		$ 6,286,604	$ 64,333		$ 64,333	$	$ 382,899	1
2	New flooring, walls, nurses station, etc for entire South Unit	2018	338,561	8,681	39	8,681		13,022	2
3	Replace oxygen room door on 1st floor	2018	2,503	64	39	64		96	3
4	Addition of locking mechanism to main entry door	2018	3,403	87	39	87		131	4
5	New air conditioners	2018	3,750	96	39	96		144	5
6	Instll new door hinges for rooms 243,246,247,248,249,251,252,253	2018	4,817	124	39	124		186	6
7	Replace 2nd floor baseboards	2018	6,639	170	39	170		255	7
8	New phone system for 2nd floor nurses station & therpay room	2018	4,561	117	39	117		175	8
9	5 new life safety doors on 2nd floor south	2018	7,132	183	39	183		274	9
10	Rebuild 2nd floor nurses call sytem	2018	6,241	160	39	160		240	10
11	New floor and signage for nurse's bathroom	2018	3,380	87	39	87		130	11
12									12
13	Security System at South Entrance	2019	2,635	205	39	205		410	13
14	Change Order to Original Nurse's Bathroom Remodeling Project	2019	2,051	190	39	190		380	14
15	Replace Pilot Assembly, Gas Valve & Flue Pipe on Boilers 1 & 2	2019	3,217	82	39	82		165	15
16	New Motor for Kitchen Hot Water Circulating Pump	2019	1,466	38	39	38		75	16
17	New Bearing Assembly for Kitchen Hot Water Circulating Pump	2019	1,486	38	39	38		76	17
18	Repairs to North Kitchen Sewer	2019	5,000	128	39	128		214	18
19	Waterproof Entryway & Elevator Pit	2019	3,080	79	39	79		118	19
20	Replace Condensor & Evaporator on Walke-In Cooler	2019	7,945	204	39	204		306	20
21	Mulch Installation, Plant Bed Expanseion & Tree Removal on Spr	2019	3,364	86	39	86		129	21
22	Install 3 New Circuits & Outlets for Window Air Condtioner, One	2019	3,600	92	39	92		131	22
23	Remove & Replace Obsolete Sprinkler Heads on Sprinkler System	2019	3,080	79	39	79		112	23
24	Install 2 New Circuits & Outlets for Intenet Hub & Air Condtione	2019	2,400	62	39	62		87	24
25	Flooring for Basement, HR Office, Medical Records, Activity Roo	2019	3,234	83	39	83		117	25
26	New Exhaust Fan for Kitchen	2019	5,250	135	39	135		179	26
27	Install Flooring for Basement, HR Office, Medical Records, Activi	2019	4,495	115	39	115		154	27
28	Flooring for Basement, HR Office, Medical Records, Activity Roo	2019	3,234	83	39	83		111	28
29	Replace flue Pipes & Clean Burners on Domestic Hot Water Tank	2019	2,881	74	39	74		92	29
30	New Cabling for IT	2019	7,400	190	39	190		237	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,733,408	$ 76,065		$ 76,065	$	$ 400,646	34

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

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 12C, Carried Forward		$ 6,733,408	$ 76,065		$ 76,065	$	$ 400,646	1
2	Remove Existing Floor & Wall Tile, Install New Floor & Wall Tile	2019	3,200	82	39	82		89	2
3	Remove Existing Flooring & Install New Flooring, Close Openings	2019	6,400	164	39	164		178	3
4	New Concrete Walkway for Sidewalk & Patio	2019	5,344	137	39	137		148	4
5	Repair Roof on Storage Room	2019	2,805	72	39	72		78	5
6	Remove Existing Floor & Wall Tile, Install New Floor & Wall Tile	2019	9,200	236	39	236		256	6
7									7
8									8
9	Replace Pump Motor on 2nd Floor Southside Heater	2020	2,934	75	39	75	(0)	75	9
10	100 Amp 3 Phase Breaker Panel for Coolers & Freezers	2020	4,300	110	39	55	(55)	110	10
11	Inspect and Repair Leaky Roof	2020	5,950	153	39	38	(114)	153	11
12	New Soft Start for Elevator 1N	2020	3,250	83	39	21	(63)	83	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)		$ 6,776,790	$ 77,177		$ 76,945	$ (232)	$ 401,816	34

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

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$ 330,176	$ 7,373	$ 66,035	$ 58,662	5	$ 279,354	71
72	Current Year Purchases	14,927	14,927	1,493	(13,434)	5	14,927	72
73	Fully Depreciated Assets	970,147				5	970,147	73
74								74
75	TOTALS	$ 1,315,250	$ 22,300	$ 67,528	$ 45,228		$ 1,264,428	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)	$ 8,597,390	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 99,477	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 144,473	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 44,996	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,666,244	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: 1/1/20 Ending: 12/31/20

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: 1/1/20 Ending: 12/31/20

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: 1/1/20 Ending: 12/31/20

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	$	5,681	$ 421,728	$	5,681	$ 421,728	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,970	138,262		1,970	138,262	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		6,124	438,359		6,124	438,359	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				209,093		209,093	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2					7,070		7,070	12
13	Other (specify): Lab	39-2					30,449		30,449	13
14	TOTAL			$	13,775	$ 998,349	$ 246,612	13,775	$ 1,244,961	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: 1/1/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (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	$ (423,047)	$ (421,954)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,410,035	3,410,035	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	216,197	216,197	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		71,399	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,203,185	$ 3,275,677	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	1,247,268	1,247,268	15
16	Equipment, at Historical Cost	415,250	3,857,960	16
17	Accumulated Depreciation (book methods)	(570,019)	(2,616,412)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	154,085	160,828	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(25,003)	(28,228)	20
21	Restricted Funds	191,514		21
22	Other Long-Term Assets (specify):		191,514	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,413,095	$ 5,070,220	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,616,280	$ 8,345,897	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 846,552	$ 935,605	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,495	13,495	28
29	Short-Term Notes Payable	1,069,800	1,164,824	29
30	Accrued Salaries Payable	145,235	145,235	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,396	15,396	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				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,090,478	$ 2,274,555	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,488,172	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)**	$	$ 4,488,172	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,090,478	$ 6,762,727	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,525,802	$ 1,583,170	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,616,280	$ 8,345,897	48

***(See instructions.)**

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,676,323	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,676,323	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	849,480	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) Rounding	(1)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 849,479	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)**	$ 2,525,802	24 *

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

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$ 11,814,055	1
2	Discounts and Allowances for all Levels	(24,921)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,789,134	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	306,195	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 306,195	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	979,548	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	37,697	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	50,551	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,067,796	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,455	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,455	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Misc Income	1,202	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,202	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,171,782	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,382,549	31
32	Health Care	5,713,283	32
33	General Administration	3,076,272	33
	B. Capital Expense		
34	Ownership	1,389,881	34
	C. Ancillary Expense		
35	Special Cost Centers	760,317	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,322,302	40
41	**Income before Income Taxes (line 30 minus line 40)****	849,480	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 849,480	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,220,082	44
45	Private Pay - Net Inpatient Revenue	646,252	45
46	Medicare - Net Inpatient Revenue	4,114,379	46
47	Other-(specify) Net Patient Revenue	808,421	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,789,134	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	1,960	2,092	$ 109,724	$ 52.45	1
2	Assistant Director of Nursing	2,865	3,076	123,049	40.00	2
3	Registered Nurses	17,113	21,525	798,065	37.08	3
4	Licensed Practical Nurses	19,205	25,123	925,186	36.83	4
5	CNAs & Orderlies	37,861	47,947	1,025,285	21.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,281	9,451	152,223	16.11	10
11	Social Service Workers	2,803	2,992	73,489	24.56	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,495	19,108	314,987	16.48	15
16	Dishwashers					16
17	Maintenance Workers	2,708	2,893	62,129	21.48	17
18	Housekeepers	12,904	14,378	225,547	15.69	18
19	Laundry	1,772	2,464	41,378	16.79	19
20	Administrator	1,992	2,080	103,475	49.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,927	10,391	191,396	18.42	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	5,081	4,275	297,606	69.62	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	137,967	167,795	$ 4,443,539 *	$ 26.48	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	200	$ 9,600	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	615	32,851	10-3	38
39	Pharmacist Consultant	240	11,988	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	53	3,443	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,108	$ 57,882		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	13,818	897,476	10-2	52
53	TOTAL (lines 50 - 52)	13,818	$ 897,476		53

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lockett, Nichole T	ADMINISTRATOR	0	$ 103,475
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 103,475

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 Healthcare Management of I	Management fees	$ 609,179
Empire Risk Management Services, I	Professional fees	11,000
Genex Services, LLC.	Professional fees	205
Global Fiscal Midwest LLC	Professional fees	30,474
Premier Pain Specialists	Professional fees	2,331
Stout Risius Ross LLC	Professional fees	5,728
Think Healthcare Resources	Professional fees	12,000
USA Risk Management Inc	Professional fees	951
Infinity Healthcare Management of I	Professional fees	1,468
See attached Schedule		134,061
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 807,397

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 98,985
Unemployment Compensation Insurance	19,835
FICA Taxes	366,918
Employee Health Insurance	250,290
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniforms	2,258
Pension	28,172
Employee backround checks	452
Other employee benefits	11,290
TOTAL (agree to Schedule V, line 22, col.8)	$ 778,200

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	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Itsca chamber of commerce	589
Dupage county health department	863
Other Licenses and dues	666
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,108

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Travel Reimbursement	838
In-State Travel	
Travel Reimbursement	8,211
Travel Reimbursement	6,990
Seminar Expense	
Education and Seminars	2,832
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 18,871

* Attach copy of IMRF notifications

**See instructions.

C. Professional Services

Vendor/Payee	Type	Amount
Infinity Funding / Sedgwick	Legal fees	73,947
Premier Destine Inc	Professional fees	704
People Powered LLC	Professional fees	2,000
Infinity H Funding	Professional fees	423
Infinity Healthcare Management of Il	Legal fees	392
Klauke Law Group LLC	Legal fees	196
McGuire Woods - 10/12/20	Legal fees	2,099
POLSINELLI	Legal fees	47,468
Johnson and Goldburg	Accounting fees	3,000
GGm	Accounting fees	6,000
Transwold	Collection Costs	108
Raymond Glick	Legal fees	(2,000)
Us legal support	Legal fees	(142)
Duran Law Ofice	Legal fees	(133)
See attached Schedule		
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)	$	134,061

Facility Name & ID Number Forest View Rehab & Nrsg Ctr # 0051516 Report Period Beginning: 1/1/20 Ending: 12/31/20

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? 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? 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 YRS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 67,935 Line 10

(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?
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 282,299
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 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.