

		FOR BHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

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 Facility ID Number: 0045534

Facility Name: Forest Villa Nsg & Rehab Ctr

Address: 6840 West Touhy Avenue Niles 60714
 Number City Zip Code

County: Cook

Telephone Number: (847) 647-8994 **Fax #** (847) 647-0500

HFS ID Number: 364481724001

Date of Initial License for Current Owners: 12/01/01

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 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) _____	
	(Title) _____	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Kimberley A. Waite, C.P.A.</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>212</u>	Skilled (SNF)	<u>212</u>	<u>77,380</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>212</u>	TOTALS	<u>212</u>	<u>77,380</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>4,205</u>	<u>1,461</u>	<u>10,197</u>	<u>15,863</u>	8
9	SNF/PED					9
10	ICF	<u>30,842</u>	<u>9,773</u>	<u>2,643</u>	<u>43,258</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>35,047</u>	<u>11,234</u>	<u>12,840</u>	<u>59,121</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.40%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 12/01/01

J. Was the facility purchased or leased after January 1, 1978?

YES Date 12/01/01 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 212 and days of care provided 10,197

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/05 Fiscal Year: 12/31/05

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

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr # 0045534 Report Period Beginning: 01/01/05 Ending: 12/31/05

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	307,894	64,447	9,636	381,977		381,977		381,977			1
2	Food Purchase		286,970		286,970	(60,262)	226,709	(618)	226,090			2
3	Housekeeping	219,292	31,933	(3,085)	248,140		248,140		248,140			3
4	Laundry	62,395	21,705		84,100		84,100		84,100			4
5	Heat and Other Utilities			175,123	175,123		175,123	(6,756)	168,367			5
6	Maintenance	92,560	24,039	68,699	185,298		185,298	2,231	187,529			6
7	Other (specify):*											7
8	TOTAL General Services	682,141	429,094	250,373	1,361,608	(60,262)	1,301,347	(5,143)	1,296,203			8
	B. Health Care and Programs											
9	Medical Director			139,600	139,600		139,600		139,600			9
10	Nursing and Medical Records	3,101,214	189,997	34,403	3,325,614		3,325,614	(17)	3,325,597			10
10a	Therapy	149,867		3,800	153,667		153,667		153,667			10a
11	Activities	157,300	43,444	4,373	205,117		205,117	(24,919)	180,198			11
12	Social Services	143,758		2,730	146,488		146,488		146,488			12
13	CNA Training											13
14	Program Transportation			11,975	11,975		11,975		11,975			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,552,139	233,441	196,881	3,982,461		3,982,461	(24,936)	3,957,525			16
	C. General Administration											
17	Administrative	111,152		226,980	338,132		338,132	(169,769)	168,363			17
18	Directors Fees											18
19	Professional Services			126,770	126,770	(15,000)	111,770	(31,035)	80,735			19
20	Dues, Fees, Subscriptions & Promotions			123,364	123,364		123,364	(82,225)	41,139			20
21	Clerical & General Office Expenses	198,678	78,548	477,895	755,121		755,121	(303,754)	451,367			21
22	Employee Benefits & Payroll Taxes			634,944	634,944	60,262	695,206	(2,000)	693,206			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,787	18,787		18,787	(8,538)	10,249			24
25	Other Admin. Staff Transportation			4,289	4,289		4,289	379	4,668			25
26	Insurance-Prop.Liab.Malpractice			230,641	230,641		230,641	5,283	235,924			26
27	Other (specify):*							28,161	28,161			27
28	TOTAL General Administration	309,830	78,548	1,843,670	2,232,048	45,262	2,277,310	(563,498)	1,713,812			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,544,110	741,083	2,290,924	7,576,117	(15,000)	7,561,117	(593,577)	6,967,540			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Villa Nsg & Rehab Ctr #0045534 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			112,660	112,660		112,660	619	113,279			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			103,541	103,541		103,541	(74,941)	28,600			32
33	Real Estate Taxes			261,436	261,436	15,000	276,436	2,342	278,778			33
34	Rent-Facility & Grounds			1,029,871	1,029,871		1,029,871	466	1,030,337			34
35	Rent-Equipment & Vehicles			9,420	9,420		9,420	3,231	12,651			35
36	Other (specify):*											36
37	TOTAL Ownership			1,516,928	1,516,928	15,000	1,531,928	(68,283)	1,463,645			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		554,558	658,053	1,212,611		1,212,611		1,212,611			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			8,111	8,111		8,111	(8,111)				41
42	Provider Participation Fee			116,070	116,070		116,070		116,070			42
43	Other (specify):*	79,469			79,469		79,469		79,469			43
44	TOTAL Special Cost Centers	79,469	554,558	782,234	1,416,261		1,416,261	(8,111)	1,408,150			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,623,579	1,295,641	4,590,086	10,509,306		10,509,306	(669,972)	9,839,334			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning:

01/01/05

Ending:

12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	(9,545)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,996)	30		9
10	Interest and Other Investment Income	(70,121)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(543)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(7,205)	24		19
20	Contributions	(7,999)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(240,244)	21		24
25	Fund Raising, Advertising and Promotional	(71,481)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,628)	20		28
29	Other-Attach Schedule	(294,885)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (711,647)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	41,676		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 41,676		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (669,972)		37

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

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

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

OHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		
	Amount	Reference
1	CVPI Dues	20
2	Sweet Shop Revenue	41
3	Medical Records Copies	21
4	Jury Duty Income	10
5	Collection - Professional Fee	19
6	Rebate Income	02
7	Patient Needs	11
8	Patient Clothing	11
9	Bank Charges	21
10	Nonallowable Interest Expense	32
11	Out of State Seminar	24
12	Nonallowable Expense	23
13	Capitalized R&M	06
14	Nonallowable Legal Fees	19
15	Nonqualified Cell Phone Expense	21
16	Nonqualified Employee Benefits Expense	25
17	Nonqualified Employee Benefits Expense	27
18		18
19		19
20		20
21		21
22		22
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96		96
97		97
98		98
99		99
100		100
101	Total	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning:

01/01/05

Ending:

12/31/05

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													1
2	Food Purchase	(618)											(618)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(9,545)		2,789									(6,756)	5
6	Maintenance	(1,627)		3,858									2,231	6
7	Other (specify):*													7
8	TOTAL General Services	(11,790)		6,647									(5,143)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(17)											(17)	10
10a	Therapy													10a
11	Activities	(24,919)											(24,919)	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(24,936)											(24,936)	16
	C. General Administration													
17	Administrative			(169,769)									(169,769)	17
18	Directors Fees													18
19	Professional Services	(34,193)		3,158									(31,035)	19
20	Fees, Subscriptions & Promotions	(83,969)		1,744									(82,225)	20
21	Clerical & General Office Expenses	(453,229)		149,475									(303,754)	21
22	Employee Benefits & Payroll Taxes	(2,000)											(2,000)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(9,131)		593									(8,538)	24
25	Other Admin. Staff Transportation			379									379	25
26	Insurance-Prop.Liab.Malpractice			5,283									5,283	26
27	Other (specify):*	(171)		28,332									28,161	27
28	TOTAL General Administration	(582,693)		19,195									(563,498)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(619,419)		25,842									(593,577)	29

STATE OF ILLINOIS

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning:

01/01/05

Ending:

Summary B

12/31/05

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(7,996)		8,615									619	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(76,121)		1,180									(74,941)	32
33	Real Estate Taxes			2,342									2,342	33
34	Rent-Facility & Grounds			466									466	34
35	Rent-Equipment & Vehicles			3,231									3,231	35
36	Other (specify):*													36
37	TOTAL Ownership	(84,117)		15,834									(68,283)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(8,111)											(8,111)	41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(8,111)											(8,111)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(711,647)		41,676									(669,972)	45

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning:

01/01/05

Ending:

12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V		\$			\$	\$
2	V						
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$			\$	\$ *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr # 0045534 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 UTILITIES	\$	NUCARE SERVICES CORP.	100.00%	\$ 2,789	\$ 2,789	15
16	V	6 REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	3,858	3,858	16
17	V	17 ADMINISTRATIVE - NON-OWNER		NUCARE SERVICES CORP.	100.00%	20,501	20,501	17
18	V	19 PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	3,158	3,158	18
19	V	20 FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	1,744	1,744	19
20	V	21 CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	149,475	149,475	20
21	V	24 SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	593	593	21
22	V	25 ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	379	379	22
23	V	26 INSURANCE		NUCARE SERVICES CORP.	100.00%	5,283	5,283	23
24	V	27 EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	26,100	26,100	24
25	V	30 DEPRECIATION		NUCARE SERVICES CORP.	100.00%	8,615	8,615	25
26	V	32 INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	1,180	1,180	26
27	V	33 REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	2,342	2,342	27
28	V	34 BUILDING RENT		NUCARE SERVICES CORP.	100.00%	466	466	28
29	V	35 EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	3,231	3,231	29
30	V	17 ADMIN. - R. HARTMAN		NUCARE SERVICES CORP.	100.00%	4,279	4,279	30
31	V	17 ADMIN. - B. CARR		NUCARE SERVICES CORP.	100.00%	11,431	11,431	31
32	V	17 ADMIN. - D. HARTMAN		NUCARE SERVICES CORP.	100.00%			32
33	V	27 EMP. BEN. - R. HARTMAN		NUCARE SERVICES CORP.	100.00%	1,455	1,455	33
34	V	27 EMP. BEN. - B. CARR		NUCARE SERVICES CORP.	100.00%	777	777	34
35	V	27 EMP. BEN. - D. HARTMAN		NUCARE SERVICES CORP.	100.00%			35
36	V							36
37	V	17 Management Fees	205,980	NUCARE SERVICES CORP.	100.00%		(205,980)	37
38	V							38
39	Total		\$ 205,980			\$ 247,656	\$ * 41,676	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Workers' Compensation	\$ 82,650	Diamond Insurance		\$ 82,650	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 82,650			\$ 82,650	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr # 0045534 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	Robert Hartman	Owner	Administrative	13.00%	See Attached	1.71	3.42%	Alloc Sal	\$ 4,279	17-07	1
2	Barry Carr	Owner	Administrative	42.00%	See Attached	4.28	8.56%	Alloc Sal	11,431	17-07	2
3	Michael Harris	Owner	Administrative	17.63%	See Attached	13.83	34.58%	Mgmt Fee	11,000	17-03	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 26,710		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning:

01/01/05

Ending: 12/31/05

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

Name of Related Organization NUCARE SERVICES CORP.
 Street Address 7257 N. LINCOLN AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 933-2600
 Fax Number (847) 933-2601

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS 904,250	11	\$ 32,587	\$	77,380	\$ 2,789	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS 904,250	11	45,083		77,380	3,858	2
3	17	ADMINISTRATIVE - NON-OWN	AVAIL. CENSUS DAYS 904,250	11	239,568	232,849	77,380	20,501	3
4	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS 904,250	11	36,902		77,380	3,158	4
5	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS 904,250	11	20,379		77,380	1,744	5
6	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS 904,250	11	1,746,738	1,454,049	77,380	149,475	6
7	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS 904,250	11	6,935		77,380	593	7
8	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS 904,250	11	4,428		77,380	379	8
9	26	INSURANCE	AVAIL. CENSUS DAYS 904,250	11	61,742		77,380	5,283	9
10	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS 904,250	11	304,996		77,380	26,100	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS 904,250	11	100,669		77,380	8,615	11
12	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS 904,250	11	13,784		77,380	1,180	12
13	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS 904,250	11	27,371		77,380	2,342	13
14	34	BUILDING RENT	AVAIL. CENSUS DAYS 904,250	11	5,450		77,380	466	14
15	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS 904,250	11	37,756		77,380	3,231	15
16	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED 20	11	50,000	50,000	2	4,279	16
17	17	ADMIN. - B. CARR	AVG. HOURS WORKED 50	11	133,580	133,580	4	11,431	17
18	17	ADMIN. - D. HARTMAN	AVG. HOURS WORKED 40	2	4,069	4,069			18
19	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED 20	11	17,006		2	1,455	19
20	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED 50	11	9,079		4	777	20
21	27	EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED 40	2	4,925				21
22									22
23									23
24									24
25	TOTALS				\$ 2,903,047	\$ 1,874,548		\$ 247,656	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 Diamond Insurance
 Street Address 40 Skokie Blvd. Suite 105
 City / State / Zip Code Northbrook, IL 60062
 Phone Number (847) 559-1022
 Fax Number ()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Workers' Compensation	Direct Allocation		\$	\$		\$ 82,650	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				\$	\$		\$ 82,650	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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										1										
2										2										
3										3										
4										4										
5	See Supplemental Schedule																			
Working Capital																				
6	LaSalle Bank		X	Working Capital				1,623,889		97,541	6									
7										7										
8	See Supplemental Schedule																			
9	TOTAL Facility Related					\$	\$	1,623,889		\$	98,721	9								
B. Non-Facility Related*																				
10	Interest Income		X							(70,121)	10									
11											11									
12											12									
13	See Supplemental Schedule																			
14	TOTAL Non-Facility Related					\$	\$			\$	(70,121)	14								
15	TOTALS (line 9+line14)					\$	\$	1,623,889		\$	28,600	15								

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 Villa Nsg & Rehab Ctr # 0045534 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term												
	Working Capital												
8	Allocate NuCare		X				\$	\$			\$	1,180	8
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital												
	B. Non-Facility Related*												
15							\$	\$			\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related												

* 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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Forest Villa Nsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0045534

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>10-30-317-030-0000</u>	<u>Long Term Care Property</u>	\$ <u>114,137.88</u>	\$ <u>114,137.88</u>
2. <u>10-30-317-044-0000</u>	<u>Long Term Care Property</u>	\$ <u>156,984.89</u>	\$ <u>156,984.89</u>
3. <u>See Attached</u>	<u>See Attached</u>	\$ <u>91,772.00</u>	\$ <u>1,968.03</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>362,894.77</u>	\$ <u>273,090.80</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Forest Villa Nsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0045534

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

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 NO

If YES, attach an explanation & 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534 Report Period Beginning:

01/01/05 Ending:

12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories _____

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Alloc From 7257 N. Lincoln Ave LLC</u>			\$ <u>6,665</u>	1
2					2
3	TOTALS			\$ 6,665	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68		89,205	3,998		3,009	(989)	5,743	68
69			35,389			(35,389)		69
70		\$ 89,205	\$ 39,387		\$ 3,009	\$ (36,378)	\$ 5,743	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 89,205	\$ 39,387		\$ 3,009	\$ (36,378)	\$ 5,743	1
2	Lights	2002	1,244		20	249	249	974	2
3	Lights	2002	2,431		20	486	486	1,864	3
4	Locks And Grab Rails	2002	1,574		20	157	157	551	4
5	Construction	2002	21,000		20	1,050	1,050	4,200	5
6	Ata Unit/Installation	2002	1,019		20	51	51	204	6
7	Wallcovering/Borders	2002	8,027		20			8,027	7
8	Border/Wallpaper	2002	1,280		20			1,280	8
9	Rebuild Storm Basin	2002	2,650		20	133	133	530	9
10	Carpet Tiles	2002	3,991		20	200	200	798	10
11	Canopy	2002	4,785		20	239	239	937	11
12	Canopy	2002	1,926		20	96	96	377	12
13	Sprinkler Heads/Flow Switch	2002	3,990		20	200	200	781	13
14	Furnish/Intall Sheet Vinyl	2002	8,830		20	442	442	1,729	14
15	Install Carpet Tiles	2002	6,240		20	312	312	1,222	15
16	Wallpaper/Borders	2002	11,182		20			11,182	16
17	Handrails	2002	8,708		20	435	435	1,705	17
18	Wallpaper Hanging	2002	4,800		20			4,800	18
19	Wallcovering/Borders	2002	711		20			711	19
20	Wallcovering For Library	2002	831		20			831	20
21	Install Recessed Lighting	2002	2,920		20	146	146	560	21
22	Reroofing	2002	29,950		20	1,498	1,498	5,616	22
23	Wallpaper Hanging	2002	1,500		20			1,500	23
24	Various Signs	2002	1,700		20	85	85	319	24
25	Canopy Consulting	2002	900		20	45	45	169	25
26	Install Vinyl Flooring	2002	6,970		20	349	349	1,307	26
27	Work On Dialysis Unit	2002	2,003		20	100	100	376	27
28	2 Sinks	2002	1,052		20	53	53	197	28
29	Landscape Architectural Serv.	2002	1,536		20	102	102	384	29
30	Wallcovering Corridor	2002	852		20			852	30
31	Nurse Call/Annunciator Panel	2002	1,586		20	106	106	396	31
32	Reface 99 Doors/Elev.Interior	2002	12,050		20	603	603	2,259	32
33	Install 2 Fire Dampers	2002	2,175		20	109	109	408	33
34	TOTAL (lines 1 thru 33)		\$ 249,618	\$ 39,387		\$ 10,255	\$ (29,132)	\$ 62,789	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 249,618	\$ 39,387		\$ 10,255	\$ (29,132)	\$ 62,789	1
2	Dialysis Plumbing	2002	10,000		20	500	500	1,833	2
3	Wallpaper Hanging	2002	1,500		20	75	75	275	3
4	Wallpaper Hanging	2002	4,400		20			4,400	4
5	Electrical And Lights	2002	1,610		20	81	81	295	5
6	Float Valve/Booster Pump	2002			20				6
7	Install 4 Door Holders	2002	895		20	45	45	175	7
8	Computer Network	2002	2,044		20	102	102	400	8
9	Final Landscape Plan	2002	319		20	21	21	78	9
10	Installation Wallcoverings	2002	16,797		20	840	840	3,079	10
11	Window Treatments	2002	1,370		20	137	137	502	11
12	Blinds	2002	876		20	88	88	321	12
13	Electrical Installation	2002	2,147		20	107	107	394	13
14	Pull Stations/Repair Panel	2002	941		20	47	47	176	14
15	Pull Stations Nurse Call	2002	912		20	46	46	167	15
16	3 Fire Dampers	2002	2,870		20	144	144	526	16
17	New Landscaping In Front	2002	14,450		20	963	963	3,452	17
18	Sprinkler System Repair	2002	1,925		20	96	96	353	18
19	Exterior Sign & Permit	2002	6,025		20	402	402	1,506	19
20	Outlets	2002	2,957		20	148	148	530	20
21	Smoke Detectors	2002	798		20	40	40	143	21
22	Electric Lines For Fire Alarm	2002	742		20	37	37	133	22
23	Electric Smoke Detectors	2002	1,103		20	55	55	198	23
24	Install Splitters	2002	955		20	48	48	171	24
25	Bitumen Roof	2002	1,150		20	58	58	201	25
26	Carpet	2002	3,505		20	501	501	1,836	26
27	Flooring	2002	986		20	66	66	230	27
28	Sign	2002	2,794		20	279	279	955	28
29	Repair Driveway And Lot	2002	2,465		20	164	164	534	29
30	Telephone Service	2002	650		20	33	33	106	30
31	Telephone Service	2002	983		20	49	49	160	31
32	Telephone Service	2002	840		20	42	42	137	32
33	Wander Guard	2002	6,410		20	321	321	988	33
34	TOTAL (lines 1 thru 33)		\$ 345,037	\$ 39,387		\$ 15,790	\$ (23,597)	\$ 87,043	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 345,037	\$ 39,387		\$ 15,790	\$ (23,597)	\$ 87,043	1
2	Skokie Paint & Wallpaper	2002	2,540		20	508	508	1,778	2
3	Tile, Toilets, Sinks, Rails, Etc	2002	5,395		20	270	270	967	3
4	Sprinkler Work	2003	1,399		20	70	70	204	4
5	Wallpaper	2003	20,581		20			20,581	5
6	Wallpaper Installation	2003	1,200		20			1,200	6
7	Landscaping	2003	2,390		20	159	159	412	7
8	Wallpaper	2003	9,773		20			9,773	8
9	Irrigation System	2003	1,073		20	72	72	179	9
10	Cctv Service	2003	1,509		20	75	75	195	10
11	Telephone Service	2003	1,068		20	107	107	276	11
12	Telephone Service	2003	1,225		20	123	123	316	12
13	Wanderguard	2003	1,564		20	78	78	196	13
14	Wallpaper Installation	2003	1,350		20			1,350	14
15	Wallpaper Installation	2003	1,455		20			1,455	15
16	Wallpaper Installation	2003	2,000		20			2,000	16
17	Pump And Water System	2003			20				17
18	Wallpaper Installation	2003	1,380		20			1,380	18
19	Wallpaper Installation	2003	1,000		20			1,000	19
20	Awning	2003	3,843		20	192	192	432	20
21	Signage For Awning	2003	1,797		20	90	90	187	21
22	Cubicle Curtains	2003	998		20	100	100	225	22
23	Cctv Service	2003	802		20	40	40	94	23
24	Telephone Service	2003	857		20	86	86	200	24
25	Meeting House Companies	2003			20				25
26	Handrail Hardware	2003	7,245		20	362	362	875	26
27	Telephone Service	2003	922		20	92	92	246	27
28	Cctv Service	2003	938		20	47	47	125	28
29	Telephone Service	2003	999		20	100	100	216	29
30	Flooring	2003	338		20	23	23	49	30
31	Flooring	2003	370		20	25	25	56	31
32	Wanderguard	2003	3,000		20	150	150	450	32
33	Wanderguard	2003	2,314		20	116	116	260	33
34	TOTAL (lines 1 thru 33)		\$ 426,362	\$ 39,387		\$ 18,675	\$ (20,712)	\$ 133,720	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 426,362	\$ 39,387		\$ 18,675	\$ (20,712)	\$ 133,720	1
2	Telephone/Wanderguard Service	2003	753		20	75	75	176	2
3	Phone System	2003	5,470		20	547	547	1,595	3
4	Over Bed Lights	2003	3,990		20	798	798	2,195	4
5	Over Bed Lights	2003	612		20	122	122	275	5
6	Name Plates	2003	625		20	125	125	260	6
7	Nurses Station, Doors	2003	16,845		20	842	842	1,965	7
8	Cubicle Curtains	2003	20,758		20	2,076	2,076	5,190	8
9	Railing Chair Guard	2003	1,200		20	60	60	140	9
10	Room Id Signs & Sliders	2003	1,763		20	88	88	184	10
11	Walk-In Freezer Compressor	2003	671		20	34	34	81	11
12	Telephone	2004	996		20	100	100	199	12
13	Telephone	2004	972		20	97	97	194	13
14	Telephone	2004	797		20	80	80	159	14
15	Drywall And Hardware	2004	6,818		20	341	341	625	15
16	Telephone	2004	621		20	62	62	114	16
17	Telephone	2004	844		20	84	84	155	17
18	Telephone	2004	753		20	75	75	138	18
19	Telephone	2004	960		20	96	96	176	19
20	Light Fixtures And Outlets	2004	3,566		20	178	178	357	20
21	Improvement	2004			20				21
22	Telephone	2004	938		20	94	94	156	22
23	Telephone	2004	908		20	91	91	151	23
24	Fixtures Outlets	2004	2,236		20	112	112	186	24
25	Architectural Professional Services	2004	1,671		20	239	239	378	25
26	Fire Equipment	2004	955		20	136	136	227	26
27	Nurse Call	2004	811		20	54	54	90	27
28	Tile	2004	2,436		20	162	162	244	28
29	Light Fixtures	2004	2,945		20	147	147	221	29
30	Wallpaper	2004	490		20	286	286	490	30
31	Carpet	2004	1,545		20	221	221	313	31
32	Telephone	2004	599		20	60	60	85	32
33	Telephone	2004	621		20	62	62	88	33
34	TOTAL (lines 1 thru 33)		\$ 511,531	\$ 39,387		\$ 26,219	\$ (13,168)	\$ 150,527	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 511,531	\$ 39,387		\$ 26,219	\$ (13,168)	\$ 150,527	1
2	Improvement	2004	1,600		20	80	80	107	2
3	Light Fixtures	2004	9,466		20	473	473	631	3
4	Telephone	2004	550		20	55	55	73	4
5	Improvement	2004	1,589		20	79	79	99	5
6	Roof	2004	2,200		20	110	110	128	6
7	Telephone Service Work	2004	931		20	93	93	116	7
8	Fire Alarm System Service	2004	742		20	106	106	133	8
9	Wanderguard Service	2004	750		20	107	107	125	9
10	Telephone Service Work	2004	808		20	81	81	94	10
11	Telephone Service Work	2004	908		20	91	91	98	11
12	Telephone Service Work	2004	821		20	82	82	89	12
13	Cubicle Curtain	2004	2,996		20	150	150	287	13
14	5 Ton Condenser	2004	933		20	187	187	296	14
15	Heating Unit	2004	1,325		20	265	265	353	15
16	Various Room Signs	2004			20				16
17	Signaling Device	2004	879		20	44	44	88	17
18	Repair Alarm System	2004	956		20	48	48	80	18
19	Concrete Work	2004	625		20	31	31	52	19
20	Signaling Device	2004	879		20	44	44	70	20
21	Electrical Work	2004	695		20	35	35	46	21
22	Electrical Work	2004	599		20	30	30	40	22
23	Landscaping	2004	935		20	47	47	55	23
24	Wallpaper	2005	883		20	883	883	883	24
25	Wood Flooring	2005	1,810		20	111	111	111	25
26	Bed Board And Heater Cover	2005	1,000		20	83	83	83	26
27	Carpeting	2005	6,062		20	650	650	650	27
28	Video Monitoring System	2005	1,744		20	145	145	145	28
29	Fire Code Door	2005	1,854		20	155	155	155	29
30	Drapery	2005	811		20	41	41	41	30
31	Window Treatments	2005	1,604		20	80	80	80	31
32	Drapery	2005	1,783		20	89	89	89	32
33	Recess Lighting	2005	6,070		20	405	405	405	33
34	TOTAL (lines 1 thru 33)		\$ 566,339	\$ 39,387		\$ 31,099	\$ (8,288)	\$ 156,229	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 566,339	\$ 39,387		\$ 31,099	\$ (8,288)	\$ 156,229	1
2	Improvement	2005	1,364		20	57	57	57	2
3	Overbed Lighting	2005	3,975		20	166	166	166	3
4	Recess Lighting	2005	922		20	31	31	31	4
5	Handrails And Hardware	2005	2,627		20	44	44	44	5
6	Curtains And Drapes	2005	2,843		20	213	213	213	6
7	Cabinet And Counter Top	2005	1,500		20	50	50	50	7
8	Recess Lighting	2005	675		20	6	6	6	8
9	Security System	2005	1,627		20	34	34	34	9
10	Cabling And Phone Upgrades	2005	28,717		20	239	239	239	10
11	Data Cable	2005	1,048		20	35	35	35	11
12	Architect Fees	2005	500		20	48	48	48	12
13	Electric Lines	2005	780		20	23	23	23	13
14	Electric Outlets	2005	540		20	5	5	5	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)		\$ 613,457	\$ 39,387		\$ 32,050	\$ (7,337)	\$ 157,180	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12G, Carried Forward	\$ 613,457	\$ 39,387		\$ 32,050	\$ (7,337)	\$ 157,180		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 613,457	\$ 39,387		\$ 32,050	\$ (7,337)	\$ 157,180		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 613,457	\$ 39,387		\$ 32,050	\$ (7,337)	\$ 157,180	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 613,457	\$ 39,387		\$ 32,050	\$ (7,337)	\$ 157,180	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 613,457	\$ 39,387		\$ 32,050	\$ (7,337)	\$ 157,180	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 613,457	\$ 39,387		\$ 32,050	\$ (7,337)	\$ 157,180	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 613,457	\$ 39,387		\$ 32,050	\$ (7,337)	\$ 157,180	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 613,457	\$ 39,387		\$ 32,050	\$ (7,337)	\$ 157,180	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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	7257 N. Lincoln Avenue, LLC		2004	2004	\$ 59,986	\$ 1,538	35	\$ 1,714	\$ 176	\$ 3,642	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation - 7257 N. Lincoln Avenue, LLC			2005	5,468	381	20	137	(244)	137	9
10	Allocation - 7257 N. Lincoln Avenue, LLC			2004	1,192	675	20	60	(615)	89	10
11											11
12	Allocation - NuCare Services Corp			2003	1,002	50	20	50		106	12
13	Allocation - NuCare Services Corp			2004	20,350	1,018	20	1,018		1,739	13
14	Allocation - NuCare Services Corp			2005	1,207	336	20	30	(306)	30	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	89,205	\$	3,998	\$	3,009	\$	(989)	\$	5,743	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr # 0045534 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 461,085	\$ 76,281	\$ 75,575	\$ (706)	10	\$ 210,063	71
72	Current Year Purchases	52,279	5,607	5,654	47	10	5,654	72
73	Fully Depreciated Assets	7,893				10	7,893	73
74								74
75	TOTALS	\$ 521,257	\$ 81,888	\$ 81,229	\$ (659)		\$ 223,610	75

D. Vehicle Depreciation (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)	\$ 1,141,379	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 121,275	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 113,279	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (7,996)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 380,790	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Forest Villa Ltd.

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>1,029,871</u>			3
4	Additions							4
5	<u>Allocate NuCare</u>				<u>466</u>			5
6								6
7	TOTAL				\$ <u>1,030,337</u>			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	<u> </u> /2006	\$ <u> </u>
13.	<u> </u> /2007	\$ <u> </u>
14.	<u> </u> /2008	\$ <u> </u>

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease .

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 854 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Facility</u>	<u>1999 Ford Van</u>	\$ <u>300.00</u>	\$ <u>3,600</u>	17
18	<u>Facility</u>	<u>2001 Chevy Silverado</u>	<u>485.00</u>	<u>5,820</u>	18
19	<u>Allocate NuCare</u>			<u>2,377</u>	19
20					20
21	TOTAL		\$ <u>785.00</u>	\$ <u>11,797</u>	21

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 264,579	\$		\$ 264,579	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			79,623			79,623	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			266,553			266,553	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				436,165		436,165	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>See Supplemental</u>					47,298	118,393		165,691	13
14	TOTAL			\$		\$ 658,053	\$ 554,558		\$ 1,212,611	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr# 0045534Report Period Beginning: 01/01/05

Ending:

12/31/05**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/05

(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	\$ 104,367	\$	1
2	Cash-Patient Deposits	4,400		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,692,850		3
4	Supply Inventory (priced at)	10,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	100,960		6
7	Other Prepaid Expenses	128,014		7
8	Accounts Receivable (owners or related parties)	1,606,613		8
9	Other(specify): <u>See Attached Schedule</u>	20,788		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,667,992	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	506,006		15
16	Equipment, at Historical Cost	473,842		16
17	Accumulated Depreciation (book methods)	(396,763)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 583,085	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,251,077	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 674,527	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,377		28
29	Short-Term Notes Payable	1,623,889		29
30	Accrued Salaries Payable	308,506		30
31	Accrued Taxes Payable (excluding real estate taxes)	32,052		31
32	Accrued Real Estate Taxes(Sch.IX-B)	117,054		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	32,133		35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	100,000		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,890,538	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,890,538	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,360,539	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,251,077	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 729,542	1
2	Restatements (describe):		2
3	<u>See Attached</u>	(45,788)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 683,754	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	676,785	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)	\$ 676,785	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,360,539	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr# 0045534Report Period Beginning: 01/01/05Ending: 12/31/05**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,073,009	1
2	Discounts and Allowances for all Levels	(743,304)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,329,705	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,750,176	6
7	Oxygen	5,986	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,756,162	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	10,244	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	805,502	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,997	19
20	Radiology and X-Ray	19,756	20
21	Other Medical Services	178,954	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,029,453	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	70,121	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 70,121	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	650	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 650	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,186,091	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,361,608	31
32	Health Care	3,982,461	32
33	General Administration	2,232,048	33
B. Capital Expense			
34	Ownership	1,516,928	34
C. Ancillary Expense			
35	Special Cost Centers	1,300,191	35
36	Provider Participation Fee	116,070	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,509,306	40
41	Income before Income Taxes (line 30 minus line 40)**	676,785	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 676,785	43

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

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

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

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

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning: 01/01/05

Ending:

12/31/05

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,829	2,086	\$ 97,843	\$ 46.90	1
2	Assistant Director of Nursing	3,104	3,268	97,846	29.94	2
3	Registered Nurses	35,129	37,902	1,013,421	26.74	3
4	Licensed Practical Nurses	20,432	22,087	516,081	23.37	4
5	CNAs & Orderlies	105,723	113,626	1,260,279	11.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,844	10,584	149,867	14.16	8
9	Activity Director	3,673	4,277	68,631	16.05	9
10	Activity Assistants	8,989	9,543	88,669	9.29	10
11	Social Service Workers	7,021	8,706	143,758	16.51	11
12	Dietician	1,909	2,206	49,621	22.49	12
13	Food Service Supervisor					13
14	Head Cook	6,095	6,720	75,091	11.17	14
15	Cook Helpers/Assistants	20,539	21,984	183,182	8.33	15
16	Dishwashers					16
17	Maintenance Workers	5,791	6,347	92,560	14.58	17
18	Housekeepers	22,916	24,711	219,292	8.87	18
19	Laundry	7,013	7,754	62,395	8.05	19
20	Administrator	2,086	2,086	90,558	43.41	20
21	Assistant Administrator					21
22	Other Administrative	290	290	20,594	71.01	22
23	Office Manager					23
24	Clerical	10,476	11,677	198,678	17.01	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	4,418	4,785	115,744	24.19	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,958	2,001	79,469	39.71	33
34	TOTAL (lines 1 - 33)	279,235	302,640	\$ 4,623,579 *	\$ 15.28	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	225	\$ 9,636	01-03	35
36	Medical Director	Monthly	139,600	09-03	36
37	Medical Records Consultant	72	3,216	10-03	37
38	Nurse Consultant	744	26,481	10-03	38
39	Pharmacist Consultant	Monthly	4,706	10-03	39
40	Physical Therapy Consultant	54	3,800	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	83	4,373	11-03	44
45	Social Service Consultant	52	2,730	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,230	\$ 194,542		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

0045534

Report Period Beginning: 01/01/05

Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions				
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount			
Mark Murphey	Administrator	0	\$ 90,558	Workers' Compensation Insurance	\$ 82,650	IDPH License Fee	\$ 3,120			
Gerry Jenich	CEO	0	20,594	Unemployment Compensation Insurance	61,248	Advertising: Employee Recruitment	20,450			
				FICA Taxes	334,096	Health Care Worker Background Check (Indicate # of checks performed)				
				Employee Health Insurance	127,427	Dues	8,866			
				Employee Meals	60,262	Subscriptions	1,152			
				Illinois Municipal Retirement Fund (IMRF)*		Advertising & Promotion	71,481			
				Other Employee Benefits	19,180	Yellow Page Advertising	1,628			
				Life Insurance	413	Licenses & Inspections	5,807			
				401K Matching Expense	7,930	See Supplemental Schedule	1,744			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 111,152	TOTAL (agree to Schedule V, line 22, col.8)		\$ 693,206	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 41,139	
B. Administrative - Other			E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
Description		Amount	Description	Line #	Amount	Description	Amount			
NuCare - Management Fees		\$ 205,980				Out-of-State Travel	\$			
Ross Bottner - Management Fees		5,000								
Michael Harris - Management Fees		11,000				In-State Travel				
See Supplemental Schedule		5,000								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 226,980	TOTAL		\$	Seminar Expense	9,656		
C. Professional Services						Allocate NuCare			593	
Vendor/Payee	Type	Amount				Entertainment Expense (agree to Sch. V, line 24, col. 8)				
See Attached Schedule	Legal	\$ 59,999				TOTAL			\$ 10,249	
FR&R	Accounting	24,735								
CDW Computer Center	Computer Services	1,981								
Emdeon Business Service	Computer Services	406								
Giftrap Corp	Computer Services	8,013								
HDSI	Computer Services	9,076								
National Datacare	Computer Services	45								
PSD Solutions	Computer Services	9,569								
Iron Administration	Corp Retirement Services	937								
Personnel Planners	Unemployment Consult	1,084								
Commitment Consulting	Collections (Adj on Page 5a)	10,925								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 126,770							

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

Report Period Beginning: 01/01/05 Ending:

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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. ILCLTC - \$12,084
- (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? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 44,242 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? No
If YES, give effective date of lease. _____
- (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. \$ 116,070
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. \$ 60,262 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT