

		FOR BHF USE					

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**2009**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2009)**

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.

<p><b>I. IDPH License ID Number:</b> <u>0045534</u></p> <p><b>Facility Name:</b> <u>Forest Villa Nursing &amp; Rehab Ctr</u></p> <p><b>Address:</b> <u>6840 West Touhy Avenue</u> <u>Niles</u> <u>60714</u>  Number City Zip Code</p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(847) 647-8994</u> <b>Fax #</b> <u>(847) 647-0500</u></p> <p><b>HFS ID Number:</b> <u>364481724001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>12/1/2001</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input checked="" type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Steve Lavenda</u> <b>Telephone Number:</b> <u>(847) 236-1111</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/09</u> to <u>12/31/09</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none; vertical-align: top;"> <b>Officer or Administrator of Provider</b> </td> <td style="border: none;">           (Signed) _____            (Type or Print Name) _____            (Title) _____         </td> </tr> <tr> <td style="border: none; vertical-align: top;"> <b>Paid Preparer</b> </td> <td style="border: none;">           (Signed) _____            (Print Name and Title) <u>Kimberley A. Waite, C.P.A.</u>            (Firm Name &amp; Address) <u>Frost, Ruttenberg &amp; 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> </td> </tr> </table> <p align="right">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</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) _____ (Title) _____	<b>Paid Preparer</b>	(Signed) _____ (Print Name and Title) <u>Kimberley A. Waite, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg &amp; 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>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) _____ (Title) _____							
<b>Paid Preparer</b>	(Signed) _____ (Print Name and Title) <u>Kimberley A. Waite, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg &amp; 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>							

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nursing & Rehab Ctr

# 0045534 Report Period Beginning: 01/01/09 Ending: 12/31/09

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 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	<u>4,709</u>	<u>1,159</u>	<u>9,070</u>	<u>14,938</u>	8
9	SNF/PED					9
10	ICF	<u>34,533</u>	<u>7,751</u>	<u>3,146</u>	<u>45,430</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>39,242</u>	<u>8,910</u>	<u>12,216</u>	<u>60,368</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.01%

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 12/1/2001

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 12/1/2001 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 9,070

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Forest Villa Nursing & Rehab Ctr # 0045534 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	352,303	67,735	10,799	430,837		430,837		430,837		1
2	Food Purchase		308,807		308,807	(64,058)	244,750	(1,419)	243,330		2
3	Housekeeping	246,427	42,989		289,416		289,416		289,416		3
4	Laundry	64,473	14,726		79,199		79,199		79,199		4
5	Heat and Other Utilities			169,821	169,821		169,821	(8,939)	160,882		5
6	Maintenance	97,007	47,895	125,817	270,719		270,719	21,575	292,294		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>760,210</b>	<b>482,152</b>	<b>306,437</b>	<b>1,548,799</b>	<b>(64,058)</b>	<b>1,484,742</b>	<b>11,217</b>	<b>1,495,958</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			129,050	129,050		129,050		129,050		9
10	Nursing and Medical Records	3,295,087	226,300	13,443	3,534,830		3,534,830	20,595	3,555,425		10
10a	Therapy	113,928			113,928		113,928		113,928		10a
11	Activities	225,852	43,144	1,767	270,763		270,763	(19,871)	250,892		11
12	Social Services	223,059		1,482	224,541		224,541		224,541		12
13	CNA Training										13
14	Program Transportation			30,852	30,852		30,852		30,852		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>3,857,926</b>	<b>269,444</b>	<b>176,594</b>	<b>4,303,964</b>		<b>4,303,964</b>	<b>724</b>	<b>4,304,688</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	179,309		216,551	395,860		395,860	(154,128)	241,732		17
18	Directors Fees										18
19	Professional Services			154,970	154,970	(7,036)	147,934	(48,675)	99,259		19
20	Dues, Fees, Subscriptions & Promotions			89,767	89,767		89,767	(54,451)	35,316		20
21	Clerical & General Office Expenses	312,793	53,704	482,706	849,203		849,203	6,158	855,361		21
22	Employee Benefits & Payroll Taxes			860,613	860,613	64,058	924,671	(18)	924,653		22
23	Inservice Training & Education										23
24	Travel and Seminar			18,652	18,652		18,652	(8,196)	10,456		24
25	Other Admin. Staff Transportation			1,176	1,176		1,176	990	2,166		25
26	Insurance-Prop.Liab.Malpractice			362,160	362,160		362,160	2,076	364,236		26
27	Other (specify):*							37,307	37,307		27
28	<b>TOTAL General Administration</b>	<b>492,102</b>	<b>53,704</b>	<b>2,186,595</b>	<b>2,732,401</b>	<b>57,022</b>	<b>2,789,423</b>	<b>(218,937)</b>	<b>2,570,485</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>5,110,238</b>	<b>805,300</b>	<b>2,669,626</b>	<b>8,585,164</b>	<b>(7,036)</b>	<b>8,578,128</b>	<b>(206,996)</b>	<b>8,371,132</b>		<b>29</b>

\*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.

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			128,242	128,242		128,242	325,654	453,896			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			72,844	72,844		72,844	523,905	596,749			32
33	Real Estate Taxes			227,041	227,041	7,036	234,077	63,418	297,495			33
34	Rent-Facility & Grounds			1,351,669	1,351,669		1,351,669	(1,351,281)	388			34
35	Rent-Equipment & Vehicles			5,700	5,700		5,700	3,337	9,037			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,785,496	1,785,496	7,036	1,792,532	(434,966)	1,357,566			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	9,990	679,940	992,058	1,681,988		1,681,988		1,681,988			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			116,070	116,070		116,070		116,070			42
43	Other (specify):*			35,429	35,429		35,429	(35,429)				43
44	<b>TOTAL Special Cost Centers</b>	9,990	679,940	1,143,557	1,833,487		1,833,487	(35,429)	1,798,058			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,120,228	1,485,240	5,598,679	12,204,147		12,204,147	(677,392)	11,526,755			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

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(263)	02		4
5	Telephone, TV & Radio in Resident Rooms	(11,123)	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	(125,506)	30		9
10	Interest and Other Investment Income	(97,683)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(454)	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	(315)	21		18
19	Entertainment	(8,867)	24		19
20	Contributions	(10,755)	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	(153,865)	21		24
25	Fund Raising, Advertising and Promotional	(35,827)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,714)	20		28
29	Other-Attach Schedule	(359,938)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (806,311)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	128,919		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 128,919		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (677,392)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Forest Villa Nursing & Rehab Ctr

ID# 0045534

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Food Discounts/Rebates	\$ (702)	02	1
2	Patient Needs	(8,515)	11	2
3	Patient Clothing	(11,356)	11	3
4	Bank Charges	(30,906)	21	4
5	COPE Dues	(6,868)	20	5
6	Annual Report	(250)	20	6
7	Marketing Employee Benefits	(18)	22	7
8	Medical Records Copies	(970)	10	8
9	Jury Duty Income	(95)	10	9
10	Building Co. - Licenses & Fees	(250)	20	10
11	Building Co. - Accounting Fees	(600)	19	11
12	Building Co. - Bank Charges	(189)	21	12
13	Building Co. - Legal Fees	(1,848)	19	13
14	Building Co - Amortization	(2,381)	31	14
15	Additional R&M	14,272	06	15
16	Non-Allowable Legal	(51,324)	19	16
17	Marketing Services	(35,429)	43	17
18	Non-Allowable Office Expense	(222,500)	21	18
19	Marketing Travel	(9)	25	19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(359,938)		49

Forest Villa Nursing & Rehab Ctr

ID# 0045534

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
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81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
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90			41
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92			43
93			44
94			45
95			46
96			47
97			48
98			49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Forest Villa Nursing & Rehab Ctr# 0045534

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(1,419)											(1,419)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(11,123)		2,184									(8,939)	5
6	Maintenance	14,272		7,303									21,575	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>1,730</b>		<b>9,487</b>									<b>11,217</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(1,065)			21,660								20,595	10
10a	Therapy													10a
11	Activities	(19,871)											(19,871)	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(20,936)</b>			<b>21,660</b>								<b>724</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(141,151)	(12,977)								(154,128)	17
18	Directors Fees													18
19	Professional Services	(53,772)	2,448	2,410	239								(48,675)	19
20	Fees, Subscriptions & Promotions	(55,664)	250	853	109								(54,451)	20
21	Clerical & General Office Expenses	(407,775)	268,547	131,489	13,897								6,158	21
22	Employee Benefits & Payroll Taxes	(18)											(18)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(8,867)		536	135								(8,196)	24
25	Other Admin. Staff Transportation	(9)		525	474								990	25
26	Insurance-Prop.Liab.Malpractice			2,076									2,076	26
27	Other (specify):*			31,698	5,609								37,307	27
28	<b>TOTAL General Administration</b>	<b>(526,105)</b>	<b>271,245</b>	<b>28,437</b>	<b>7,486</b>								<b>(218,937)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(545,311)</b>	<b>271,245</b>	<b>37,923</b>	<b>29,146</b>								<b>(206,996)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Forest Villa Nursing & Rehab Ctr# 0045534

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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	(125,506)	443,258	7,748	155								325,654	30
31	Amortization of Pre-Op. & Org.	(2,381)	2,381											31
32	Interest	(97,683)	616,772	4,563	253								523,905	32
33	Real Estate Taxes		56,462	6,956									63,418	33
34	Rent-Facility & Grounds		(1,351,669)	388									(1,351,281)	34
35	Rent-Equipment & Vehicles			3,337									3,337	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>(225,570)</b>	<b>(232,796)</b>	<b>22,992</b>	<b>408</b>								<b>(434,966)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(35,429)											(35,429)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(35,429)</b>											<b>(35,429)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(806,311)</b>	<b>38,449</b>	<b>60,915</b>	<b>29,555</b>								<b>(677,392)</b>	<b>45</b>

**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		Forest Villa Property, LLC		Building Co.
				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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 1,078,272	Forest Villa Property, LLC		\$	\$ (1,078,272)	1
2	V	34 Rental Income - RE Taxes	273,397				(273,397)	2
3	V	32 Interest	38,078			654,850	616,772	3
4	V	20 Licenses & Fees				250	250	4
5	V	19 Accounting Fees				600	600	5
6	V	21 Closing Costs				268,358	268,358	6
7	V	21 Bank Charges				189	189	7
8	V	19 Legal				1,848	1,848	8
9	V	30 Depreciation				443,258	443,258	9
10	V	31 Amortization				2,381	2,381	10
11	V	33 Real Estate Taxes				56,462	56,462	11
12	V							12
13	V							13
14	Total		\$ 1,389,747			\$ 1,428,196	\$ * 38,449	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	NUCARE SERVICES CORP.	100.00%	\$ 2,184	\$	2,184	15
16	V	6 REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	7,303		7,303	16
17	V	17 ADMIN. - NON-OWNER		NUCARE SERVICES CORP.	100.00%	16,424		16,424	17
18	V	19 PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	2,410		2,410	18
19	V	20 FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	853		853	19
20	V	21 CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	131,489		131,489	20
21	V	24 SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	536		536	21
22	V	25 ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	525		525	22
23	V	26 INSURANCE		NUCARE SERVICES CORP.	100.00%	2,076		2,076	23
24	V	27 EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	31,698		31,698	24
25	V	30 DEPRECIATION		NUCARE SERVICES CORP.	100.00%	7,748		7,748	25
26	V	32 INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	4,563		4,563	26
27	V	33 REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	6,956		6,956	27
28	V	34 PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	388		388	28
29	V	35 EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	3,337		3,337	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V	17 Management Fees	157,575	NUCARE SERVICES CORP.	100.00%			(157,575)	37
38	V								38
39	Total		\$ 157,575			\$ 218,490	\$ *	60,915	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	10 CLINICAL SALARIES	\$	CLINICAL CONSULTING SERVICES, LLC	100.00%	\$ 21,660	\$ 21,660
16	V	19 PROFESSIONAL FEES		CLINICAL CONSULTING SERVICES, LLC	100.00%	239	239
17	V	20 DUES, LICENSE & INSPECTION		CLINICAL CONSULTING SERVICES, LLC	100.00%	109	109
18	V	21 OFFICE WAGES		CLINICAL CONSULTING SERVICES, LLC	100.00%	13,033	13,033
19	V	21 OFFICE EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	864	864
20	V	24 CONTINUING EDUCATION / SEMINAR		CLINICAL CONSULTING SERVICES, LLC	100.00%	135	135
21	V	25 AUTO EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	474	474
22	V	27 PAYROLL TAXES		CLINICAL CONSULTING SERVICES, LLC	100.00%	2,408	2,408
23	V	27 OTHER EMPLOYEE BENEFITS		CLINICAL CONSULTING SERVICES, LLC	100.00%	3,201	3,201
24	V	30 DEPRECIATION		CLINICAL CONSULTING SERVICES, LLC	100.00%	155	155
25	V	32 INTEREST		CLINICAL CONSULTING SERVICES, LLC	100.00%	253	253
26	V						
27	V						
28	V	17 Management Fees	12,977	CLINICAL CONSULTING SERVICES, LLC	100.00%		(12,977)
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 12,977			\$ 42,532	\$ * 29,555

\* 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	22 Workers' Compensation	\$ 167,298	Diamond Insurance		\$ 167,298	\$	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	<b>Total</b>		\$ 167,298			\$ 167,298	\$ *	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: 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		
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	<b>Total</b>		\$			\$	\$ *	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: 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		
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	<b>Total</b>		\$			\$	\$ *	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: 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		
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	<b>Total</b>		\$			\$	\$ *	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: 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		
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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name & ID Number Forest Villa Nursing & Rehab Ctr # 0045534 Report Period Beginning: 01/01/09 Ending: 12/31/09

## 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	Michael Harris	Owner	Administrative	17.63%	See Attached	13.83	34.58%	Mgmt. Fees	\$ 46,000	17-3	1
2	David Hartman	Owner	Administrative	10.00%	See Attached	2.53	6.33%	Salary	36,451	17-1	2
3	Mark Hartman	Relative	Administrative	0	See Attached	20.00	50.00%	Salary	17,213	17-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 99,664		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 Nursing & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 Nursing & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 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

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	1,224,940	13	\$ 34,570	\$ 77,380	\$ 2,184	1	
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	1,224,940	13	115,610	77,380	7,303	2	
3	17	ADMIN. - NON-OWNER	AVAIL. CENSUS DAYS	1,224,940	13	260,001	260,001	77,380	16,424	3
4	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,224,940	13	38,148	77,380	2,410	4	
5	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	1,224,940	13	13,506	77,380	853	5	
6	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	1,224,940	13	2,081,498	1,811,576	77,380	131,489	6
7	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,224,940	13	8,486	77,380	536	7	
8	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	1,224,940	13	8,304	77,380	525	8	
9	26	INSURANCE	AVAIL. CENSUS DAYS	1,224,940	13	32,870	77,380	2,076	9	
10	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	1,224,940	13	501,784	77,380	31,698	10	
11	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,224,940	13	122,648	77,380	7,748	11	
12	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,224,940	13	72,233	77,380	4,563	12	
13	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,224,940	13	110,113	77,380	6,956	13	
14	34	PARKING LOT RENT	AVAIL. CENSUS DAYS	1,224,940	13	6,145	77,380	388	14	
15	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,224,940	13	52,826	77,380	3,337	15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 3,458,744	\$ 2,071,577	\$ 218,490	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nursing & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 CLINICAL CONSULTING SERVICES, LLC  
 Street Address 7257 N. LINCOLN AVENUE  
 City / State / Zip Code LINCOLNWOOD, IL 60712  
 Phone Number ( 847) 933-2600  
 Fax Number ( 847) 933-2601

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	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS 1,224,940	13	\$ 342,887	\$ 342,887	77,380	\$ 21,660	1
2	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS 1,224,940	13	3,780		77,380	239	2
3	20	DUES, LICENSE & INSPECTIO	AVAIL. CENSUS DAYS 1,224,940	13	1,732		77,380	109	3
4	21	OFFICE WAGES	AVAIL. CENSUS DAYS 1,224,940	13	206,311	206,311	77,380	13,033	4
5	21	OFFICE EXPENSE	AVAIL. CENSUS DAYS 1,224,940	13	13,685		77,380	864	5
6	24	CONTINUING EDUCATION / ST	AVAIL. CENSUS DAYS 1,224,940	13	2,134		77,380	135	6
7	25	AUTO EXPENSE	AVAIL. CENSUS DAYS 1,224,940	13	7,503		77,380	474	7
8	27	PAYROLL TAXES	AVAIL. CENSUS DAYS 1,224,940	13	38,113		77,380	2,408	8
9	27	OTHER EMPLOYEE BENEFITS	AVAIL. CENSUS DAYS 1,224,940	13	50,678		77,380	3,201	9
10	30	DEPRECIATION	AVAIL. CENSUS DAYS 1,224,940	13	2,448		77,380	155	10
11	32	INTEREST	AVAIL. CENSUS DAYS 1,224,940	13	4,013		77,380	253	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				\$ 673,284	\$ 549,198		\$ 42,531	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nursing & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/09

Ending: 12/31/09

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		\$	\$		\$ 167,298	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				\$	\$		\$ 167,298	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nursing & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/09

Ending: 12/31/09

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nursing & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/09

Ending: 12/31/09

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nursing & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/09

Ending: 12/31/09

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nursing & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/09

Ending: 12/31/09

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nursing & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/09

Ending: 12/31/09

**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 \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nursing & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/09

Ending: 12/31/09

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Forest Villa Nursing & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/09

Ending:

12/31/09

**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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	HUD		X	Mortgage			\$	\$ 17,327,688		\$ 160,491	1								
2											2								
3											3								
4											4								
5	See Supplemental Schedule										5								
<b>Working Capital</b>																			
6	Private Bank		X	line of Credit				1,864,463		56,813	6								
7	Private Loan		X	Term Loan						10,031	7								
8	See Supplemental Schedule									494,358	8								
9	TOTAL Facility Related						\$	\$ 19,192,151		\$ 721,693	9								
<b>B. Non-Facility Related*</b>																			
10	Interest Income		X							(97,683)	10								
11	Judy Harris Trust		X							6,000	11								
12	Interest Income - Bldg. Co		X							(38,078)	12								
13	See Supplemental Schedule									4,816	13								
14	TOTAL Non-Facility Related						\$	\$		\$ (124,945)	14								
15	TOTALS (line 9+line14)						\$	\$ 19,192,151		\$ 596,748	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 &amp; ID Number

Forest Villa Nursing &amp; Rehab Ctr

# 0045534

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	<b>TOTAL Long-Term</b>									7										
<b>Working Capital</b>																				
8	Building Co. - Private Bank		Loan			\$	\$			\$ 436,025										
9	Building Co		Related Party Loan							58,333										
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Working Capital</b>									494,358										
<b>B. Non-Facility Related*</b>																				
15	Allocated from NuCare		X			\$	\$			\$ 4,563										
16	Allocated from Clinical Cons.									253										
17										17										
18										18										
19										19										
20	<b>TOTAL Non-Facility Related</b>									4,816										

\* 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.)

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.		\$	<b>434,993</b>	<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>357,442</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(77,551)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>368,010</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>7,036</b>	<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ <u>18,764</u> For <u>2004</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>297,495</b>	<b>7</b>
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	<u>271,123</u>	<u>8</u>	
	2005	<u>281,602</u>	<u>9</u>	
	2006	<u>298,251</u>	<u>10</u>	
	2007	<u>340,137</u>	<u>11</u>	
	2008	<u>350,486</u>	<u>12</u>	
<b>2009 Accrual = \$350,486 x 1.05 = \$368,010</b>				
<b>Beginning accrual adjusted for the reclass of rental payments for real estate taxes, for credits received at the closing, reverse of the estimated accrual.</b>				
<b>Allocated from NuCare \$6,956</b>				
				<b>FOR BHF USE ONLY</b>
	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2008	\$	<b>13</b>
	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

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

SEE ACCOUNTANTS' COMPILATION REPORT





Facility Name & ID Number Forest Villa Nursing & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/09

Ending:

12/31/09

**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

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

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Land</u>		<u>2009</u>	<u>\$ 2,330,768</u>	<u>1</u>
2	<u>Alloc. From 7257 N. Lincoln/Clinical Consulting</u>		<u>2004</u>	<u>9,602</u>	<u>2</u>
3	<b>TOTALS</b>			<b>\$ 2,340,370</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nursing & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/09

Ending:

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**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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various		2002		263,767		20	11,982	11,982	134,554	9
10	Various		2003		126,077		20	5,829	5,829	81,799	10
11	Various		2004		63,669		20	4,532	4,532	26,524	11
12	Various		2005		70,739		20	5,592	5,592	25,966	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 Nursing & Rehab Ctr

# 0045534

Report Period Beginning:

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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	Related Building Company (Pages 12F & 12G)	9,756,249	243,290		325,994	82,704	87,415	67
68	Related Party Allocations (Pages 12H & 12I)	115,594	3,590		4,029	439	22,814	68
69	Financial Statement Depreciation		128,242			(128,242)		69
70	TOTAL (lines 4 thru 69)	\$ 10,396,095	\$ 375,122		\$ 357,958	\$ (17,164)	\$ 379,072	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Forest Villa Nursing &amp; Rehab Ctr

# 0045534

Report Period Beginning:

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## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 10,396,095	\$ 375,122		\$ 357,958	\$ (17,164)	\$ 379,072	1
2	Replace Carpet In Lobby	2006	2,584		20	369	369	1,446	2
3	Replace Carpet In Lobby	2006	2,584		20	369	369	1,446	3
4	Service On Telephone System	2006	842		20	84	84	330	4
5	Armstron Vct Tile And Glue	2006	3,137		20	209	209	837	5
6	Roof Repair	2006	2,000		20	100	100	358	6
7	Replace Carpet In Lobby	2006	2,607		20	372	372	1,335	7
8	Fixtures/Electronics	2006	1,408		20	70	70	252	8
9	Equipment For Sprinkler System	2006	2,065		20	295	295	1,008	9
10	Asphalt And Curve Concrete	2006	8,000		20	533	533	1,733	10
11	New Flashing For New Roof	2006	4,700		20	235	235	764	11
12	Cubicle Curtains	2006	2,348		20	235	235	841	12
13	50 Boxes Armstrong Vct Tile	2007	2,059		20	137	137	389	13
14	9 Canopy Fixtures	2007	1,437		20	72	72	204	14
15	Cubicle Curtains Vegas Pearl	2007	5,283		20	528	528	1,585	15
16	Drapes Pinch Pleated Vegas Pearl	2007	2,740		20	274	274	799	16
17	Exixting Electrical Box	2007	1,200		20	60	60	160	17
18	Drapes Pair Pinch Pleated Drapes	2007	3,914		20	391	391	1,044	18
19	6 Lock Seam Sash Door Rod	2007	1,009		20	50	50	135	19
20	40 Simkar Fco/Wco Pullchain With Outlet	2007	3,492		20	175	175	437	20
21	Furnish/Install 2 Mecho Shades	2007	1,019		20	51	51	123	21
22	Cubicle Curtains	2007	2,201		20	220	220	532	22
23	Landscaping Project	2007	6,000		20	400	400	900	23
24	Installation Of Keri Card System For Employee Entrance	2007	3,195		20	456	456	1,065	24
25	16 Pcs Drapes	2008	5,479		20	548	548	1,096	25
26	Water Heater	2008	7,516		20	626	626	1,201	26
27	Change Laminate On 15 Doors	2008	3,155		20	158	158	276	27
28	Replace 3 Places On Roof	2008	6,300		20	315	315	551	28
29	Landscaping Work	2008	5,500		20	367	367	611	29
30	10 Recessed Ceiling Lights And 2 Switches	2008	1,200		20	60	60	80	30
31	Laminate 12 Doors	2008	2,658		20	133	133	166	31
32	Generator	2008	2,584		20	129	129	151	32
33	Fireproofing Job	2009	3,900		20	464	464	464	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 10,500,211	\$ 375,122		\$ 366,443	\$ (8,679)	\$ 401,391	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 10,500,211	\$ 375,122		\$ 366,443	\$ (8,679)	\$ 401,391	1
2	Fencing Materials Around A/C Units	2009	4,652		20	155	155	155	2
3	Pulled Cables For Base Stations	2009	3,977		20	99	99	99	3
4	Parking Lot Repairs	2009	29,000		20	967	967	967	4
5	Tadiran Ipx500 Telephone System	2009	25,275		20	1,474	1,474	1,474	5
6	Tadiran Ipx500 Telephone System	2009	25,275		20	1,264	1,264	1,264	6
7	56 Additional Ports; 64 Port Authorization Flexset Telephones; 1 U	2009	13,985		20	699	699	699	7
8	1 Commercial Water Softener	2009	3,150		20	131	131	131	8
9	Roof Repairs	2009	4,200		20	35	35	35	9
10	Relocate Pump Booster	2009	4,261		20	36	36	36	10
11	Boiler Room Work	2009	5,000		20	188	188	188	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 10,618,986	\$ 375,122		\$ 371,491	\$ (3,631)	\$ 406,439	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 10,618,986	\$ 375,122		\$ 371,491	\$ (3,631)	\$ 406,439	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)		\$ 10,618,986	\$ 375,122		\$ 371,491	\$ (3,631)	\$ 406,439	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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		\$ 10,618,986	\$ 375,122		\$ 371,491	\$ (3,631)	\$ 406,439	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)	\$ 10,618,986	\$ 375,122		\$ 371,491	\$ (3,631)	\$ 406,439	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Building Company Information</b>								1
2	<b>Buildings:</b>								2
3		1964	9,709,136	238,579	35	323,638	85,059	85,059	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9									9
10	<b>Site Improvements</b>	1964	47,113	4,711	20	2,356	(2,355)	2,356	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Building Company Information Continued</b>		\$	\$		\$	\$	\$	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	<b>TOTAL (12F &amp; 12G lines 1 thru 33)</b>		\$ 9,756,249	\$ 243,290		\$ 325,994	\$ 82,704	\$ 87,415	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	<b>Related Party Information</b>		\$	\$		\$	\$		1
2	<b>Buildings:</b>								2
3	Allocated From 7257 N. Lincoln Ave LLC	2004	81,869	2,099	35	2,339	240	14,327	3
4	Allocated From Clinical Consulting Services	2004	4,548	117	35	130	13	796	4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	Allocated From NuCare Services Corp.	2003	740	25	20	37	12	227	9
10	Allocated From NuCare Services Corp.	2004	15,022	500	20	752	252	4,294	10
11	Allocated From NuCare Services Corp.	2005	891	30	20	45	15	216	11
12	Allocated From NuCare Services Corp.	2006	1,208	40	20	60	20	203	12
13	Allocated From NuCare Services Corp.	2008	1,273	42	20	64	22	80	13
14	Allocated From NuCare Services Corp.	2009	448	15	20	7	(8)	7	14
15									15
16	Allocated From 7257 N. Lincoln Ave LLC	2005	7,463	590	20	482	(108)	2,076	16
17	Allocated From 7257 N. Lincoln Ave LLC	2004	1,627	94	20	81	(13)	448	17
18									18
19	Allocated From Clinical Consulting Services	2005	415	33	20	27	(6)	115	19
20	Allocated From Clinical Consulting Services	2004	90	5	20	5		25	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

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 Nursing & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/09

Ending:

12/31/09

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								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 (12H & 12I lines 1 thru 33)	\$ 115,594	\$ 3,590		\$ 4,029	\$ 439	\$ 22,814	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 546,830	\$ 3,048	\$ 77,797	\$ 74,749	10	\$ 360,483	71
72	Current Year Purchases	1,034,333	201,232	3,040	(198,192)	10	3,040	72
73	Fully Depreciated Assets	213,575		486	486	10	213,575	73
74								74
75	TOTALS	\$ 1,794,738	\$ 204,280	\$ 81,323	\$ (122,957)		\$ 577,098	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		Conversion Van	2007	\$ 7,200	\$	\$ 1,082	\$ 1,082	5	\$ 3,231	76
77										77
78										78
79										79
80	TOTALS			\$ 7,200	\$	\$ 1,082	\$ 1,082		\$ 3,231	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)	\$ 14,761,294	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 579,402	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 453,896	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (125,506)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 986,768	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.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

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

If NO, see instructions.  YES  NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$			3
4	Additions						4
5							5
6	Allocated from NuCare (Parking Lot Rental)			388			6
7	TOTAL			\$ 388			7

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2006 Toyota Tundra	\$ 475.00	\$ 5,700	17
18	Allocated from NuCare			3,337	18
19					19
20					20
21	TOTAL		\$ 475.00	\$ 9,037	21

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. \_\_\_\_\_/2009 \$ \_\_\_\_\_

13. \_\_\_\_\_/2010 \$ \_\_\_\_\_

14. \_\_\_\_\_/2011 \$ \_\_\_\_\_

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

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

**D. NUMBER OF CNAs TRAINED**

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost			Units	Cost								
1	Licensed Occupational Therapist	39 - 03	hrs	\$				\$	370,271	\$			\$	370,271	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs						148,866		5,729			154,595	2	
3	Licensed Recreational Therapist		hrs												3	
4	Licensed Physical Therapist	39 - 03	hrs						411,729					411,729	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 prescrpts								413,177			413,177	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs												10	
11	Academic Education		hrs												11	
12	Other (specify):														12	
13	Other (specify): <u>See Supplemental</u>				9,990				61,192		261,034			332,216	13	
14	TOTAL			\$	9,990			\$	992,058	\$	679,940		\$	1,681,988	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 Nursing & Rehab Ctr# 0045534Report Period Beginning: 01/01/09Ending: 12/31/09

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 907,913	\$ 3,087,286	1
2	Cash-Patient Deposits	2,023	2,023	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,659,155	1,659,155	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	118,527	118,527	6
7	Other Prepaid Expenses	321,041	321,041	7
8	Accounts Receivable (owners or related parties)	2,078,630	2,078,630	8
9	Other(specify): <u>See Attached Schedule</u>	138,661	2,189,170	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 5,225,950	\$ 9,455,832	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		2,330,768	13
14	Buildings, at Historical Cost		9,709,136	14
15	Leasehold Improvements, at Historical Cost	730,854	777,967	15
16	Equipment, at Historical Cost	751,890	1,751,725	16
17	Accumulated Depreciation (book methods)	(927,419)	(1,370,677)	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>	70,654	569,373	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 625,979	\$ 13,768,292	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,851,929	\$ 23,224,124	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 421,966	\$ 421,969	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,864,463	1,864,463	29
30	Accrued Salaries Payable	572,569	572,569	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,984	24,984	31
32	Accrued Real Estate Taxes(Sch.IX-B)	311,548	368,010	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	781,106	1,380,408	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,976,636	\$ 4,632,403	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		17,327,688	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 17,327,688	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,976,636	\$ 21,960,091	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,875,293	\$ 1,264,033	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,851,929	\$ 23,224,124	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,611,688</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Additional Bad Debts</b>	(100,000)	<b>3</b>
<b>4</b>	<b>Medicare Bad Debts</b>	2,876	<b>4</b>
<b>5</b>	<b>Interest Expense</b>	938	<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,515,502</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	969,791	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(610,000)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>359,791</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,875,293</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 10,457,160	1
2	Discounts and Allowances for all Levels	(578,917)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 9,878,243</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,226,519	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 2,226,519</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	669,737	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30,786	19
20	Radiology and X-Ray	18,529	20
21	Other Medical Services	231,437	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 950,489</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	210	24
25	Interest and Other Investment Income***	97,683	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 97,893</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	20,794	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 20,794</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 13,173,938</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,548,799	31
32	Health Care	4,303,964	32
33	General Administration	2,732,401	33
<b>B. Capital Expense</b>			
34	Ownership	1,785,496	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,717,417	35
36	Provider Participation Fee	116,070	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 12,204,147</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>969,791</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 969,791</b>	<b>43</b>

\* 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 Nursing & Rehab Ctr**

# **0045534**

Report Period Beginning:

**01/01/09**

Ending:

**12/31/09**

**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	1,984	2,014	\$ 98,998	\$ 49.15	1
2	Assistant Director of Nursing	1,877	1,933	81,471	42.15	2
3	Registered Nurses	28,452	31,559	1,202,066	38.09	3
4	Licensed Practical Nurses	18,040	19,906	560,794	28.17	4
5	CNAs & Orderlies	103,870	111,546	1,252,971	11.23	5
6	CNA Trainees					6
7	Licensed Therapist	151	151	9,990	66.16	7
8	Rehab/Therapy Aides	6,783	7,293	113,928	15.62	8
9	Activity Director	8,433	9,091	106,319	11.69	9
10	Activity Assistants	9,605	10,333	119,533	11.57	10
11	Social Service Workers	9,407	10,232	223,059	21.80	11
12	Dietician	1,784	2,120	58,298	27.50	12
13	Food Service Supervisor					13
14	Head Cook	5,993	6,672	80,963	12.13	14
15	Cook Helpers/Assistants	22,017	23,764	213,042	8.96	15
16	Dishwashers					16
17	Maintenance Workers	4,367	4,803	97,007	20.20	17
18	Housekeepers	24,419	26,619	246,427	9.26	18
19	Laundry	6,913	7,341	64,473	8.78	19
20	Administrator	2,020	2,086	143,446	68.77	20
21	Assistant Administrator	549	566	17,213	30.41	21
22	Other Administrative	306	306	18,650	60.95	22
23	Office Manager					23
24	Clerical	16,920	19,221	312,793	16.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,869	3,061	98,787	32.27	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	276,759	300,617	\$ 5,120,228 *	\$ 17.03	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	232	\$ 10,799	01-03	35
36	Medical Director	Monthly	129,050	09-03	36
37	Medical Records Consultant	Monthly	4,224	10-03	37
38	Nurse Consultant	Monthly	6,304	10-03	38
39	Pharmacist Consultant	Monthly	2,915	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	31	1,767	11-03	44
45	Social Service Consultant	26	1,482	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	289	\$ 156,541		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

**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	
Margo Marasa	Administrator	0	\$ 106,995	Workers' Compensation Insurance	\$ 167,298	IDPH License Fee	\$ 5,654	
Mark S. Hartman	Assist. Admin.	0	17,213	Unemployment Compensation Insurance	37,712	Advertising: Employee Recruitment		
Kathlen Brander	Dir. Of Regulat. Mgmt.	0	5,766	FICA Taxes	359,546	Health Care Worker Background Check		
Marilyn Flaherty	VP of MC Reimb.	0	12,884	Employee Health Insurance	235,905	(Indicate # of checks performed <u>300</u> )	3,000	
David Hartman	Executive Dir.	10%	36,451	Employee Meals	64,058	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	13,539	
				Dental Insurance	8,430	Licenses & Inspections	12,160	
				Life Insurance	246	Advertising & Promotion	37,541	
				401K Matching Expense	10,482	Alloc. From NuCare	853	
				Other Employee Benefits	40,975	See Supplemental Schedule	109	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	(35,827)	
						Yellow page advertising	(1,714)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 179,309	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 924,653		\$ 35,315		
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 Services -Administrative Fee			\$ 157,575				Out-of-State Travel	\$
Clinical Consulting - Administrative Fee			12,977					
Michael Harris			46,000				In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 216,552	TOTAL		\$	Seminar Expense	9,785
							Alloc. From NuCare	536
							Alloc. From Clinical Consulting	135
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 154,969				TOTAL	\$ 10,456

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Forest Villa Nursing &amp; Rehab Ctr

# 0045534

Report Period Beginning: 01/01/09

Ending: 12/31/09

**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 \$16,918
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 53,283 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. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 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. \$ 64,058 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 263
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
- 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. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.