



Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

# 0045534 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Private Pay	4 Other	Total	
8	SNF			<u>9,998</u>	<u>9,998</u>	8
9	SNF/PED					9
10	ICF	<u>38,538</u>	<u>7,357</u>	<u>2,154</u>	<u>48,049</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>38,538</u>	<u>7,357</u>	<u>12,152</u>	<u>58,047</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.02%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 12/01/2001

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 12/01/2001 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 8,139

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: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr # 0045534 Report Period Beginning: 01/01/10 Ending: 12/31/10

**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	383,656	48,617	10,505	442,778		442,778		442,778		1
2	Food Purchase		328,952		328,952	(70,226)	258,726	(1,115)	257,611		2
3	Housekeeping	249,844	40,548		290,392		290,392		290,392		3
4	Laundry	82,562	23,302		105,864		105,864		105,864		4
5	Heat and Other Utilities			199,081	199,081		199,081	(11,378)	187,703		5
6	Maintenance	100,582	46,357	125,464	272,403		272,403	7,566	279,969		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>816,644</b>	<b>487,776</b>	<b>335,050</b>	<b>1,639,470</b>	<b>(70,226)</b>	<b>1,569,244</b>	<b>(4,927)</b>	<b>1,564,317</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			100,500	100,500		100,500		100,500		9
10	Nursing and Medical Records	3,379,009	378,169	87,980	3,845,158		3,845,158	26,259	3,871,417		10
10a	Therapy	129,234		1,792	131,026		131,026		131,026		10a
11	Activities	107,777	41,427	841	150,045		150,045	(24,427)	125,618		11
12	Social Services	191,218		13,546	204,764		204,764		204,764		12
13	CNA Training										13
14	Program Transportation			1,403	1,403		1,403		1,403		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>3,807,238</b>	<b>419,596</b>	<b>206,062</b>	<b>4,432,896</b>		<b>4,432,896</b>	<b>1,832</b>	<b>4,434,728</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	196,298		457,352	653,650		653,650	(347,612)	306,038		17
18	Directors Fees										18
19	Professional Services			153,535	153,535	(3,925)	149,610	1,082	150,692		19
20	Dues, Fees, Subscriptions & Promotions			107,650	107,650		107,650	(59,008)	48,642		20
21	Clerical & General Office Expenses	333,043	53,656	215,515	602,214		602,214	21,366	623,580		21
22	Employee Benefits & Payroll Taxes			789,803	789,803	70,226	860,029	(37)	859,992		22
23	Inservice Training & Education										23
24	Travel and Seminar			19,241	19,241		19,241	(7,582)	11,659		24
25	Other Admin. Staff Transportation			3,347	3,347		3,347	1,302	4,649		25
26	Insurance-Prop.Liab.Malpractice			287,273	287,273		287,273	10,372	297,645		26
27	Other (specify):*							42,501	42,501		27
28	<b>TOTAL General Administration</b>	<b>529,341</b>	<b>53,656</b>	<b>2,033,716</b>	<b>2,616,713</b>	<b>66,301</b>	<b>2,683,014</b>	<b>(337,616)</b>	<b>2,345,398</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>5,153,223</b>	<b>961,028</b>	<b>2,574,828</b>	<b>8,689,079</b>	<b>(3,925)</b>	<b>8,685,154</b>	<b>(340,711)</b>	<b>8,344,443</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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			132,938	132,938		132,938	423,861	556,799			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			66,488	66,488		66,488	972,913	1,039,401			32
33	Real Estate Taxes			5,171	5,171	3,925	9,096	400,371	409,467			33
34	Rent-Facility & Grounds			1,843,606	1,843,606		1,843,606	(1,843,305)	301			34
35	Rent-Equipment & Vehicles			8,193	8,193		8,193	4,097	12,290			35
36	Other (specify):*							199,664	199,664			36
37	<b>TOTAL Ownership</b>			2,056,396	2,056,396	3,925	2,060,321	157,601	2,217,922			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	11,204	570,211	827,907	1,409,322		1,409,322		1,409,322			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):*			267,527	267,527		267,527	(267,527)				43
44	<b>TOTAL Special Cost Centers</b>	11,204	570,211	1,211,504	1,792,919		1,792,919	(267,527)	1,525,392			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,164,427	1,531,239	5,842,728	12,538,394		12,538,394	(450,637)	12,087,757			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				4
5	Telephone, TV & Radio in Resident Rooms	(13,791)	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	(550,521)	30		9
10	Interest and Other Investment Income	(36,960)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(416)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(7,129)	24		19
20	Contributions	(22,055)	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	(120,000)	21		24
25	Fund Raising, Advertising and Promotional	(28,362)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(13,182)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,007)	20		28
29	Other-Attach Schedule	(356,972)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (1,151,394)		\$	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)	700,757		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 700,757		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (450,637)		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	

SEE ACCOUNTANTS' COMPILATION REPORT

Forest Villa Nsg & Rehab Ctr

ID# 0045534

Report Period Beginning: 01/01/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Patient Needs	\$ (12,780)	11	1
2	Patient Clothing	(11,647)	11	2
3	Bank Charges	(17,076)	21	3
4	COPE Dues	(7,619)	20	4
5	Building Company Accounting Fees	(6,375)	19	5
6	Quest Management Fees	(87,527)	43	6
7	Non-Allowable Expense	(180,000)	43	7
8	Annual Report	(250)	20	8
9	Non-Allowable Travel	(6)	25	9
10	Non-Allowable Seminars	(1,683)	24	10
11	Additional R&M	7,541	06	11
12	Non-Allowable Legal	(8,312)	19	12
13	Building Company Amortization	(8,157)	31	13
14	Building Company Bank Charges	(2,033)	21	14
15	Building Company Professional Fees	(7,000)	19	15
16	Marketing Employee Benefits	(37)	22	16
17	Records Copies	(1,272)	10	17
18	Jury Duty Income	(52)	10	18
19	Miscellaneous Income	(134)	21	19
20	Food Rebates	(699)	02	20
21	Maintenance Refund	(5,854)	06	21
22	Non-Allowable Interest	(6,000)	32	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>	(356,972)		49

Forest Villa Nsg & Rehab Ctr

ID# 0045534

Report Period Beginning: 01/01/10

Ending: 12/31/10

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
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
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 Nsg & Rehab Ctr# 0045534

Report Period Beginning:

01/01/10

Ending:

12/31/10

## 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	(1,115)											(1,115)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(13,791)		2,413									(11,378)	5
6	Maintenance	1,687		5,879									7,566	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(13,219)</b>		<b>8,292</b>									<b>(4,927)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(1,324)				27,583							26,259	10
10a	Therapy													10a
11	Activities	(24,427)											(24,427)	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>(25,751)</b>				<b>27,583</b>							<b>1,832</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(374,088)	58,535	(32,059)							(347,612)	17
18	Directors Fees													18
19	Professional Services	(21,687)	13,375	9,363		31							1,082	19
20	Fees, Subscriptions & Promotions	(60,293)		1,254		31							(59,008)	20
21	Clerical & General Office Expenses	(152,425)	2,033	149,078		22,680							21,366	21
22	Employee Benefits & Payroll Taxes	(37)											(37)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(8,812)		1,073		157							(7,582)	24
25	Other Admin. Staff Transportation	(6)		1,092		216							1,302	25
26	Insurance-Prop.Liab.Malpractice		8,835	1,537									10,372	26
27	Other (specify):*			33,163	2,367	6,971							42,501	27
28	<b>TOTAL General Administration</b>	<b>(243,260)</b>	<b>24,243</b>	<b>(177,528)</b>	<b>60,902</b>	<b>(1,973)</b>							<b>(337,616)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(282,230)</b>	<b>24,243</b>	<b>(169,236)</b>	<b>60,902</b>	<b>25,610</b>							<b>(340,711)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(550,521)	966,865	7,382		135							423,861	30
31	Amortization of Pre-Op. & Org.	(8,157)	8,157											31
32	Interest	(42,960)	1,012,294	3,391		188							972,913	32
33	Real Estate Taxes		393,760	6,611									400,371	33
34	Rent-Facility & Grounds		(1,843,606)	301									(1,843,305)	34
35	Rent-Equipment & Vehicles			4,097									4,097	35
36	Other (specify):*		199,664										199,664	36
37	<b>TOTAL Ownership</b>	<b>(601,638)</b>	<b>737,134</b>	<b>21,782</b>		<b>323</b>							<b>157,601</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):*	(267,527)											(267,527)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(267,527)</b>											<b>(267,527)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(1,151,394)</b>	<b>761,377</b>	<b>(147,455)</b>	<b>60,902</b>	<b>25,933</b>							<b>(450,637)</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	\$ 1,843,606	Forest Villa Property, LLC	100.00%	\$	(1,843,606)	1
2	V	32 Interest	14,587	Forest Villa Property, LLC	100.00%	1,026,881	1,012,294	2
3	V	19 Accounting Fees		Forest Villa Property, LLC	100.00%	6,375	6,375	3
4	V	36 MIP Insurance		Forest Villa Property, LLC	100.00%	199,664	199,664	4
5	V	26 Insurance Expense		Forest Villa Property, LLC	100.00%	8,835	8,835	5
6	V	33 Real Estate Taxes		Forest Villa Property, LLC	100.00%	393,760	393,760	6
7	V	21 Bank Charges		Forest Villa Property, LLC	100.00%	2,033	2,033	7
8	V	19 Professional Fees		Forest Villa Property, LLC	100.00%	7,000	7,000	8
9	V	30 Depreciation Expense		Forest Villa Property, LLC	100.00%	966,865	966,865	9
10	V	31 Amortization		Forest Villa Property, LLC	100.00%	8,157	8,157	10
11	V			Forest Villa Property, LLC	100.00%			11
12	V							12
13	V							13
14	Total		\$ 1,858,193			\$ 2,619,570	\$ * 761,377	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	NUCARE SERVICES CORP.	100.00%	\$ 2,413	\$ 2,413
16	V	6 REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	5,879	5,879
17	V	17 ADMIN. - NON-OWNER		NUCARE SERVICES CORP.	100.00%	15,205	15,205
18	V	19 PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	9,363	9,363
19	V	20 FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	1,254	1,254
20	V	21 CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	149,078	149,078
21	V	24 SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	1,073	1,073
22	V	25 ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	1,092	1,092
23	V	26 INSURANCE		NUCARE SERVICES CORP.	100.00%	1,537	1,537
24	V	27 EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	33,163	33,163
25	V	30 DEPRECIATION		NUCARE SERVICES CORP.	100.00%	7,382	7,382
26	V	32 INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	3,391	3,391
27	V	33 REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	6,611	6,611
28	V	34 PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	301	301
29	V	35 EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	4,097	4,097
30	V						
31	V	17 MANAGEMENT FEES	389,293				(389,293)
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 389,293			\$ 241,838	\$ * (147,455)

\* 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	17 ADMIN. - R. HARTMAN		NUCARE SERVICES CORP.	100.00%	5,049	\$	5,049	15
16	V								16
17	V	17 ADMIN. - B. CARR		NUCARE SERVICES CORP.	100.00%	8,548		8,548	17
18	V	17 ADMIN. - M. HARTMAN		NUCARE SERVICES CORP.	100.00%	44,938		44,938	18
19	V								19
20	V	27 EMP. BEN. - R. HARTMAN		NUCARE SERVICES CORP.	100.00%	204		204	20
21	V								21
22	V	27 EMP. BEN. - B. CARR		NUCARE SERVICES CORP.	100.00%	346		346	22
23	V	27 EMP. BEN. - M. HARTMAN		NUCARE SERVICES CORP.	100.00%	1,817		1,817	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 60,902	\$ *	60,902	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%	\$ 27,583	\$	27,583	15
16	V	19 PROFESSIONAL FEES		CLINICAL CONSULTING SERVICES, LLC	100.00%	31		31	16
17	V	20 DUES, LICENSE & INSPECTION		CLINICAL CONSULTING SERVICES, LLC	100.00%	31		31	17
18	V	21 OFFICE WAGES		CLINICAL CONSULTING SERVICES, LLC	100.00%	20,151		20,151	18
19	V	21 OFFICE EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	2,529		2,529	19
20	V	24 CONTINUING EDUCATION / SEMINAR		CLINICAL CONSULTING SERVICES, LLC	100.00%	157		157	20
21	V	25 AUTO EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	216		216	21
22	V	27 PAYROLL TAXES		CLINICAL CONSULTING SERVICES, LLC	100.00%	3,283		3,283	22
23	V	27 OTHER EMPLOYEE BENEFITS		CLINICAL CONSULTING SERVICES, LLC	100.00%	3,688		3,688	23
24	V	30 DEPRECIATION		CLINICAL CONSULTING SERVICES, LLC	100.00%	135		135	24
25	V	32 INTEREST		CLINICAL CONSULTING SERVICES, LLC	100.00%	188		188	25
26	V								26
27	V	17 MANAGEMENT FEES	32,059					(32,059)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 32,059			\$ 57,992	\$ *	25,933	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	22 Workers Compensation	\$ 36,942	Diamond Insurance	40.00%	\$ 36,942	\$	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>		\$ 36,942			\$ 36,942	\$ *	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: 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.

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr # 0045534 Report Period Beginning: 01/01/10 Ending: 12/31/10

## 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	\$ 36,000	17-3	1
2	David Hartman	Owner	Administrative	10.00%	See Attached	0.75	1.88%	Salary	36,099	17-1	2
3	Mark Hartman	Relative	Administrative	0.00%	See Attached	10.00	25.00%	Sal/Al Salary	78,239	17-1;17-7	3
4	Barry Carr	Owner	Administrative	42.00%	See Attached	2.14	4.28%	Alloc Sal	8,548	17-7	4
5	Robert Hartman	Relative	Administrative	0.00%	See Attached	1.26	2.52%	Alloc Sal	5,049	17-7	5
6											6
7	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered allowable by the										7
8	IL Dept. of HFS.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 163,935		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/10

Ending: 12/31/10

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/10

Ending: 12/31/10

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	1,226,110	16	\$ 38,227	\$ 77,380	\$ 2,413	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	1,226,110	16	93,156	77,380	5,879	2
3	17	ADMIN. - NON-OWNER	AVAIL. CENSUS DAYS	1,226,110	16	240,928	240,928	15,205	3
4	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,226,110	16	148,362	77,380	9,363	4
5	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	1,226,110	16	19,864	77,380	1,254	5
6	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	1,226,110	16	2,362,190	2,024,369	149,078	6
7	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,226,110	16	16,998	77,380	1,073	7
8	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	1,226,110	16	17,306	77,380	1,092	8
9	26	INSURANCE	AVAIL. CENSUS DAYS	1,226,110	16	24,362	77,380	1,537	9
10	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	1,226,110	16	525,475	77,380	33,163	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,226,110	16	116,967	77,380	7,382	11
12	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,226,110	16	53,729	77,380	3,391	12
13	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,226,110	16	104,761	77,380	6,611	13
14	34	PARKING LOT RENT	AVAIL. CENSUS DAYS	1,226,110	16	4,765	77,380	301	14
15	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,226,110	16	64,914	77,380	4,097	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,832,004	\$ 2,265,297	\$ 241,838	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/10

Ending: 12/31/10

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	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED	20	16	80,000	1	5,049	1
2									2
3	17	ADMIN. - B. CARR	AVG. HOURS WORKED	10	6	40,000	2	8,548	3
4	17	ADMIN. - M. HARTMAN	AVG. HOURS WORKED	10	1	44,938	10	44,938	4
5									5
6	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	20	16	3,234	1	204	6
7									7
8	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED	10	6	1,617	2	346	8
9	27	EMP. BEN. - M. HARTMAN	AVG. HOURS WORKED	10	1	1,817	10	1,817	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					\$ 171,606	\$ 164,938	\$ 60,902	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/10

Ending: 12/31/10

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	1,226,110	16	\$ 437,066	\$ 437,066	77,380	27,583	1
2	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,226,110	16	484		77,380	31	2
3	20	DUES, LICENSE & INSPECTIO	AVAIL. CENSUS DAYS	1,226,110	16	488		77,380	31	3
4	21	OFFICE WAGES	AVAIL. CENSUS DAYS	1,226,110	16	319,300	319,300	77,380	20,151	4
5	21	OFFICE EXPENSE	AVAIL. CENSUS DAYS	1,226,110	16	40,077		77,380	2,529	5
6	24	CONTINUING EDUCATION / ST	AVAIL. CENSUS DAYS	1,226,110	16	2,480		77,380	157	6
7	25	AUTO EXPENSE	AVAIL. CENSUS DAYS	1,226,110	16	3,430		77,380	216	7
8	27	PAYROLL TAXES	AVAIL. CENSUS DAYS	1,226,110	16	52,028		77,380	3,283	8
9	27	OTHER EMPLOYEE BENEFITS	AVAIL. CENSUS DAYS	1,226,110	16	58,440		77,380	3,688	9
10	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,226,110	16	2,132		77,380	135	10
11	32	INTEREST	AVAIL. CENSUS DAYS	1,226,110	16	2,985		77,380	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	TOTALS					\$ 918,910	\$ 756,366		\$ 57,992	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/10

Ending: 12/31/10

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		\$	\$		\$ 36,942	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				\$	\$		\$ 36,942	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/10

Ending: 12/31/10

**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 Nsg & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/10

Ending: 12/31/10

**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 Nsg & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/10

Ending: 12/31/10

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

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

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.

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 Nsg & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/10

Ending: 12/31/10

**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 Nsg & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/10

Ending: 12/31/10

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

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

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.

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 Nsg & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/10

Ending:

12/31/10

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			\$	\$ 17,188,162		\$ 1,026,881	1								
2											2								
3											3								
4											4								
5	See Supplemental Schedule										5								
<b>Working Capital</b>																			
6	Private Bank		X	Line of Credit				1,750,204			20,738	6							
7	Private Loan		X	Term Loan							39,750	7							
8	See Supplemental Schedule											8							
9	TOTAL Facility Related						\$	\$ 18,938,366		\$ 1,087,369	9								
<b>B. Non-Facility Related*</b>																			
10	Interest Income		X								(36,960)	10							
11	Judy Harris Trust	X									6,000	11							
12	Interest Income- Building		X								(14,587)	12							
13	See Supplemental Schedule										(2,421)	13							
14	TOTAL Non-Facility Related						\$	\$		\$	(47,968)	14							
15	TOTALS (line 9+line14)						\$	\$ 18,938,366		\$	1,039,401	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 199,664 Line # 36

\* 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 Nsg &amp; Rehab Ctr

# 0045534

Report Period Beginning:

01/01/10

Ending:

12/31/10

## 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							\$	\$			\$	8								
9												9								
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Working Capital</b>											14								
	<b>B. Non-Facility Related*</b>																			
15	Allocated From NuCare		X				\$	\$			\$	3,391	15							
16	Allocated From CCS		X									188	16							
17	Non-Allowable Interest	X										(6,000)	17							
18													18							
19													19							
20	<b>TOTAL Non-Facility Related</b>											(2,421)	20							

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)







Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/10

Ending:

12/31/10

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

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

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

**XI. OWNERSHIP COSTS:**

	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>Allocated From 7257 N. Lincoln</u>			<u>9,593</u>	<u>2</u>
3	<b>TOTALS</b>			<b>\$ 2,340,361</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

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				\$	\$		\$	\$	\$
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Various		2002	263,767		20	11,810	11,810	146,364
10	Various		2003	126,077		20	5,828	5,828	87,627
11	Various		2004	63,667		20	4,277	4,277	30,802
12	Various		2005	70,739		20	5,594	5,594	31,558
13	Various		2006	32,275		20	2,873	2,873	13,222
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

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		9,756,249	766,898		325,994	(440,904)	413,409	67
68		182,627	5,718		7,320	1,602	30,911	68
69			58,808			(58,808)		69
70		\$ 10,495,401	\$ 831,424		\$ 363,695	\$ (467,729)	\$ 753,893	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 Nsg &amp; Rehab Ctr

# 0045534

Report Period Beginning:

01/01/10

Ending:

12/31/10

## 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>		\$ 10,495,401	\$ 831,424		\$ 363,695	\$ (467,729)	\$ 753,893	1
2	50 Boxes Armstrong Vct Tile	2007	2,059		20	137	137	526	2
3	9 Canopy Fixtures	2007	1,437		20	72	72	275	3
4	Cubicle Curtains Vegas Pearl	2007	5,283		20	528	528	2,113	4
5	Drapes Pinch Pleated Vegas Pearl	2007	2,740		20	274	274	1,073	5
6	Existing Electrical Box	2007	1,200		20	60	60	220	6
7	Drapes Pair Pinch Pleated Drapes	2007	3,914		20	391	391	1,435	7
8	6 Lock Seam Sash Door Rod	2007	1,009		20	50	50	185	8
9	40 Simkar Fco/Wco Pullchain With Outlet	2007	3,492		20	175	175	611	9
10	Furnish/Install 2 Mecho Shades	2007	1,019		20	51	51	174	10
11	Cubicle Curtains	2007	2,201		20	220	220	752	11
12	Landscaping Project	2007	6,000		20	400	400	1,300	12
13	Installation Of Keri Card System For Employee Entrance	2007	3,195		20	456	456	1,521	13
14	16 Pcs Drapes	2008	5,479		20	548	548	1,644	14
15	Water Heater	2008	7,516		20	626	626	1,827	15
16	Change Laminate On 15 Doors	2008	3,155		20	158	158	434	16
17	Replace 3 Places On Roof	2008	6,300		20	315	315	866	17
18	Landscaping Work	2008	5,500		20	367	367	978	18
19	10 Recessed Ceiling Lights And 2 Switches	2008	1,200		20	60	60	140	19
20	Laminate 12 Doors	2008	2,658		20	133	133	299	20
21	Generator	2008	2,584		20	129	129	280	21
22	Fireproofing Job	2009	3,900		20	557	557	1,021	22
23	Fencing Materials Around A/C Units	2009	4,652		20	233	233	388	23
24	Pulled Cables For Base Stations	2009	3,977		20	199	199	298	24
25	Parking Lot Repairs	2009	29,000		20	2,900	2,900	3,867	25
26	Tadiran Ipx500 Telephone System	2009	25,275		20	2,528	2,528	4,002	26
27	Tadiran Ipx500 Telephone System	2009	25,275		20	2,528	2,528	3,791	27
28	56 Additional Ports; 64 Port Authorization Flexset Telephones; 1 U	2009	13,985		20	1,399	1,399	2,098	28
29	1 Commercial Water Softener	2009	3,150		20	263	263	394	29
30	Roof Repairs	2009	4,200		20	210	210	245	30
31	Relocate Pump Booster	2009	4,261		20	213	213	249	31
32	Boiler Room Work	2009	5,000		20	250	250	438	32
33	Structural Engineer Services- For Ramp	2010	3,952		20	181	181	181	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 10,689,971	\$ 831,424		\$ 380,305	\$ (451,119)	\$ 787,518	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>		\$ 10,689,971	\$ 831,424		\$ 380,305	\$ (451,119)	\$ 787,518	1
2	Rm 200-20610 Boxes Rubbercove Base, 50 Cases Vct, 2 Buckets G	2010	3,130		20	117	117	117	2
3	Wall Coverings, Tile Planks	2010	10,374		20	475	475	475	3
4	Roof Replacement With New Modified Bitumen System	2010	4,450		20	93	93	93	4
5	Asphalt Repairs	2010	6,300		20	158	158	158	5
6	Room Signs, Ada Signage	2010	8,470		20	141	141	141	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 (lines 1 thru 33)</b>		\$ 10,722,695	\$ 831,424		\$ 381,289	\$ (450,135)	\$ 788,503	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		\$ 10,722,695	\$ 831,424		\$ 381,289	\$ (450,135)	\$ 788,503	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)	\$ 10,722,695	\$ 831,424		\$ 381,289	\$ (450,135)	\$ 788,503	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		\$ 10,722,695	\$ 831,424		\$ 381,289	\$ (450,135)	\$ 788,503	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)	\$ 10,722,695	\$ 831,424		\$ 381,289	\$ (450,135)	\$ 788,503	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	506,277	35	323,638	(182,639)	408,697	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	3,141	20	2,356	(785)	4,712	10
11	<b>Additional Depreciation</b>			257,480			(257,480)		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.

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	\$ 766,898		\$ 325,994	\$ (440,904)	\$ 413,409	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	81,791	2,097	35	2,337	240	16,650	3
4	Allocated From Clinical Consulting Services	2004	4,544	117	35	130	13	925	4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	Allocated From 7257 N. Lincoln Ave LLC	2004	7,456	325	20	481	156	2,556	9
10	Allocated From 7257 N. Lincoln Ave LLC	2005	1,625		20	81	81	528	10
11									11
12	Allocated From Clinical Consulting Services	2004	414	18	20	27	9	142	12
13	Allocated From Clinical Consulting Services	2005	90		20	5	5	29	13
14									14
15	Allocated From NuCare Services Corp.	2003	739	27	20	37	10	263	15
16	Allocated From NuCare Services Corp.	2004	15,008	547	20	751	204	5,041	16
17	Allocated From NuCare Services Corp.	2005	890	32	20	45	13	260	17
18	Allocated From NuCare Services Corp.	2006	1,206	44	20	60	16	263	18
19	Allocated From NuCare Services Corp.	2008	1,272	46	20	64	18	144	19
20	Allocated From NuCare Services Corp.	2009	64,446	2,350	20	3,222	872	4,030	20
21	Allocated From NuCare Services Corp.	2010	3,146	115	20	80	(35)	80	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 Nsg & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/10

Ending:

12/31/10

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)		\$ 182,627	\$ 5,718		\$ 7,320	\$ 1,602	\$ 30,911	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Forest Villa Nsg & Rehab Ctr

# 0045534

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	\$ 1,464,035	\$ 266,168	\$ 168,755	\$ (97,413)	10	\$ 514,539	71
72	Current Year Purchases	75,185	8,826	5,557	(3,269)	10	5,557	72
73	Fully Depreciated Assets	330,643		269	269	10	330,643	73
74								74
75	TOTALS	\$ 1,869,863	\$ 274,994	\$ 174,581	\$ (100,413)		\$ 850,740	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	Facility	Conversion Van	2007	\$ 7,200	\$ 882	\$ 882	\$ (0)	5	\$ 4,113	76
77		Allocated From NuCare	2010	559	20	47	27	5	47	77
78										78
79										79
80	TOTALS			\$ 7,759	\$ 902	\$ 929	\$ 27		\$ 4,160	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)	\$ 14,940,678	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,107,320	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 556,799	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (550,521)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,643,402	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	CIP- Cost Seg Group	\$ 1,226,345	92
93			93
94			94
95		\$ 1,226,345	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	<u>Allocated From NuCare (Parking Lot)</u>				<u>301</u>			6
7	<b>TOTAL</b>				\$ <b>301</b>			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: \$ 4,096

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Facility</u>	<u>2006 Toyota Tundra</u>	\$ <u>475.00</u>	\$ <u>950</u>	17
18	<u>Facility</u>	<u>2010 Ford F-150</u>	\$ <u>579.00</u>	\$ <u>7,243</u>	18
19					19
20					20
21	<b>TOTAL</b>		\$ <b>1,054.00</b>	\$ <b>8,193</b>	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. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

\* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<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**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
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		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	39 - 03	hrs					\$ 279,658							\$ 279,658	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					184,011							184,011	2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39 - 03	hrs					342,410							342,410	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							328,082					328,082	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>				11,204			21,828		242,129					275,161	13
14	TOTAL				\$ 11,204			\$ 827,907		\$ 570,211					\$ 1,409,322	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Forest Villa Nsg & Rehab Ctr**

# **0045534**

Report Period Beginning: **01/01/10**

Ending: **12/31/10**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/10** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 606,139	\$ 1,284,303	1
2	Cash-Patient Deposits	3,294	3,294	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,512,611	1,512,611	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	111,000	118,693	6
7	Other Prepaid Expenses	515,330	515,330	7
8	Accounts Receivable (owners or related parties)	1,069,661	2,373,887	8
9	Other(specify): <u>See Attached Schedule</u>	15,768	1,283,714	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,833,803	\$ 7,091,832	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	767,530	814,643	15
16	Equipment, at Historical Cost	826,493	1,826,328	16
17	Accumulated Depreciation (book methods)	(1,060,357)	(2,470,480)	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>	79,577	1,612,292	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 613,243	\$ 13,822,687	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,447,046	\$ 20,914,519	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 474,995	\$ 478,495	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,271	1,271	28
29	Short-Term Notes Payable	1,750,204	1,750,204	29
30	Accrued Salaries Payable	369,568	369,568	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,761	4,761	31
32	Accrued Real Estate Taxes(Sch.IX-B)		392,823	32
33	Accrued Interest Payable		85,225	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	765,859	936,257	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,366,658	\$ 4,018,604	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		17,188,162	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>	\$	\$ 17,188,162	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,366,658	\$ 21,206,766	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,080,388	\$ (292,247)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,447,046	\$ 20,914,519	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>1,875,293</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding Adjustment</b>	<b>2</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,875,295</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(194,907)</b>	<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	<b>(600,000)</b>	<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>(794,907)</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>1,080,388</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	\$ 10,217,544	1
2	Discounts and Allowances for all Levels	(982,684)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 9,234,860</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,063,300	6
7	Oxygen	1,692	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 2,064,992</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	648,423	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	39,110	19
20	Radiology and X-Ray	15,222	20
21	Other Medical Services	295,900	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 998,655</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	10	24
25	Interest and Other Investment Income***	36,960	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 36,970</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>	8,010	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 8,010</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 12,343,487</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,639,470	31
32	Health Care	4,432,896	32
33	General Administration	2,616,713	33
<b>B. Capital Expense</b>			
34	Ownership	2,056,396	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,676,849	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>\$ 12,538,394</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(194,907)</b>	<b>41</b>
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (194,907)</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 Nsg & Rehab Ctr**

# **0045534**

Report Period Beginning:

**01/01/10**

Ending:

**12/31/10**

**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	1,037	1,410	\$ 64,122	\$ 45.48	1
2	Assistant Director of Nursing	1,430	1,543	57,573	37.31	2
3	Registered Nurses	39,493	42,465	1,250,606	29.45	3
4	Licensed Practical Nurses	19,229	21,195	586,061	27.65	4
5	CNAs & Orderlies	105,945	114,431	1,331,283	11.63	5
6	CNA Trainees					6
7	Licensed Therapist	151	151	11,204	74.20	7
8	Rehab/Therapy Aides	7,508	8,072	129,234	16.01	8
9	Activity Director					9
10	Activity Assistants	9,353	9,918	107,777	10.87	10
11	Social Service Workers	7,450	8,235	191,218	23.22	11
12	Dietician	1,827	2,098	58,918	28.08	12
13	Food Service Supervisor					13
14	Head Cook	7,631	8,323	106,608	12.81	14
15	Cook Helpers/Assistants	21,932	23,626	218,130	9.23	15
16	Dishwashers					16
17	Maintenance Workers	4,720	5,244	100,582	19.18	17
18	Housekeepers	23,972	26,192	249,844	9.54	18
19	Laundry	8,060	8,807	82,562	9.37	19
20	Administrator	3,775	3,893	110,033	28.26	20
21	Assistant Administrator	1,197	1,267	36,575	28.87	21
22	Other Administrative	2,351	2,390	49,690	20.79	22
23	Office Manager	1,834	2,086	85,136	40.81	23
24	Clerical	16,650	18,772	247,907	13.21	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	1,934	2,095	89,364	42.66	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	287,479	312,213	\$ 5,164,427 *	\$ 16.54	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	227	\$ 10,505	01-03	35
36	Medical Director	Monthly	100,500	09-03	36
37	Medical Records Consultant	Monthly	265	10-03	37
38	Nurse Consultant	Monthly	5,940	10-03	38
39	Pharmacist Consultant	Monthly	3,455	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		1,792	10a-03	43
44	Activity Consultant	15	841	11-03	44
45	Social Service Consultant	228	13,546	12-03	45
46	Other(specify)				46
47	<u>Geriatric Unit Director</u>	Monthly	45,870	10-03	47
48					48
49	TOTAL (lines 35 - 48)	470	\$ 182,714		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	649	\$ 32,450	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	649	\$ 32,450		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	0.00%	\$ 108,033	Workers' Compensation Insurance	\$ 36,942	IDPH License Fee	\$ 995	
Mark Hartman	Asst. Admin.	0.00%	33,301	Unemployment Compensation Insurance	36,166	Advertising: Employee Recruitment	16,821	
Jan Kaval	Administrator	0.00%	2,000	FICA Taxes	358,840	Health Care Worker Background Check		
Amanda Andrews	Asst. Admin	0.00%	3,274	Employee Health Insurance	271,035	(Indicate # of checks performed <u>492</u> )	9,918	
David Hartman	Executive Director	10.00%	36,099	Employee Meals	70,226	Patient Background Checks		
Kathleen Brander	Dir. Reg Mgmt	0.00%	764	Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	14,162	
See Supplemental Schedule			12,827	401 K Matching	12,652	Advertising & Promotions	30,369	
TOTAL (agree to Schedule V, line 17, col. 1)				Other Employee Benefits	61,816	Licenses & Inspections	5,461	
(List each licensed administrator separately.)			\$ 196,298	Dental Insurance	12,315	See Supplemental Schedule	1,285	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount		\$ 859,992	Less: Public Relations Expense	( )	
NuCare Services -Administrative Fee			\$ 389,293			Non-allowable advertising	(28,362)	
Clinical Consulting - Administrative Fee			32,059			Yellow page advertising	(2,007)	
Michael Harris			36,000					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 457,352	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services							Out-of-State Travel	\$
Vendor/Payee	Type		Amount				In-State Travel	
See Attached	Legal		\$ 62,050				Seminar Expense	10,429
Frost, Ruttenberg & Rothblatt	Accounting		32,310				Allocated From NuCare	1,073
Personnel Planners	Unemployment Consultant		1,400				Allocated From CCS	157
James Hamilton	Appraisal		3,500				Entertainment Expense	( )
CDW Computer Centers	Computer Services		1,167				(agree to Sch. V, line 24, col. 8)	
Emdeon	Computer Services		897				TOTAL	\$ 11,659
Giftrap	Computer Services		6,830					
HDSI	Computer Services		6,929					
MDI Achieve	Computer Services		3,495					
PSD Solutions	Computer Services		10,958					
Achieve Accreditation	Survey Consulting		13,720					
See Supplemental Schedule			10,279					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 153,535	TOTAL		\$		
(If total legal fees exceed \$5,000, attach copy of invoices.)								

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

# 0045534

Report Period Beginning:

01/01/10

Ending:

12/31/10

**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. IL Council on LTC \$18,277
- (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. \$ 22,593 Line 10-02
- (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. \$ 70,226 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln14  
d. Have vehicle usage logs been maintained? No  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ 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.