

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0045534</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Forest Villa Nrsg. & Rehab Ctr.</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>6840 W. Touhy</u> <u>Niles</u> <u>60648</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(847) 647-8994</u> Fax # <u>(847) 647-0500</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Kimberley A. Waite, C.P.A.</u></td></tr><tr><td>(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td></tr><tr><td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Kimberley A. Waite, C.P.A.</u>	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630												
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	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																								
Date of Initial License for Current Owners: <u>12/01/01</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Forest Villa Nrsg. & Rehab Ctr.

0045534 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>9,776</u>	<u>9,776</u>	8
9	SNF/PED					9
10	ICF	<u>33,824</u>	<u>6,105</u>	<u>2,502</u>	<u>42,431</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>33,824</u>	<u>6,105</u>	<u>12,278</u>	<u>52,207</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.47%

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 7,965

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: 12/31/2011 Fiscal Year: 12/31/2011

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	387,212	47,289	16,468	450,969		450,969		450,969			1
2	Food Purchase		319,888		319,888	(74,022)	245,866	(373)	245,493			2
3	Housekeeping	239,827	28,627		268,454		268,454		268,454			3
4	Laundry	77,082	32,461		109,543		109,543		109,543			4
5	Heat and Other Utilities			177,328	177,328		177,328	2,182	179,510			5
6	Maintenance	109,886	60,528	157,765	328,179		328,179	8,159	336,338			6
7	Other (specify):*											7
8	TOTAL General Services	814,007	488,793	351,561	1,654,361	(74,022)	1,580,339	9,968	1,590,307			8
	B. Health Care and Programs											
9	Medical Director			81,750	81,750		81,750		81,750			9
10	Nursing and Medical Records	3,653,179	605,140	105,986	4,364,305		4,364,305	(42,326)	4,321,979			10
10a	Therapy			1,181	1,181		1,181		1,181			10a
11	Activities	109,734	29,862		139,596		139,596		139,596			11
12	Social Services	78,348		4,077	82,425		82,425		82,425			12
13	CNA Training											13
14	Program Transportation			586	586		586		586			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,841,261	635,002	193,580	4,669,843		4,669,843	(42,326)	4,627,517			16
	C. General Administration											
17	Administrative	175,124		466,116	641,240		641,240	(291,759)	349,481			17
18	Directors Fees											18
19	Professional Services			207,075	207,075	(27,614)	179,461	9,041	188,502			19
20	Dues, Fees, Subscriptions & Promotions			108,203	108,203		108,203	(58,619)	49,584			20
21	Clerical & General Office Expenses	405,078	65,038	113,508	583,624		583,624	112,450	696,074			21
22	Employee Benefits & Payroll Taxes			881,658	881,658	74,022	955,680		955,680			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,965	18,965		18,965	(4,788)	14,177			24
25	Other Admin. Staff Transportation			3,936	3,936		3,936	885	4,821			25
26	Insurance-Prop.Liab.Malpractice			333,183	333,183		333,183	17,932	351,115			26
27	Other (specify):*							53,093	53,093			27
28	TOTAL General Administration	580,202	65,038	2,132,644	2,777,884	46,408	2,824,292	(161,766)	2,662,526			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,235,470	1,188,833	2,677,785	9,102,088	(27,614)	9,074,474	(194,124)	8,880,350			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' COMPILATION REPORT
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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			152,228	152,228		152,228	522,445	674,673			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			70,550	70,550		70,550	992,786	1,063,336			32
33	Real Estate Taxes					27,614	27,614	498,702	526,316			33
34	Rent-Facility & Grounds			1,883,384	1,883,384		1,883,384	(1,882,998)	386			34
35	Rent-Equipment & Vehicles			6,948	6,948		6,948	3,024	9,972			35
36	Other (specify):*							85,508	85,508			36
37	TOTAL Ownership			2,113,110	2,113,110	27,614	2,140,724	219,468	2,360,192			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	6,062	463,919	939,682	1,409,663		1,409,663		1,409,663			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			319,907	319,907		319,907		319,907			42
43	Other (specify):*	131,374		228,708	360,082		360,082	(360,082)	0			43
44	TOTAL Special Cost Centers	137,436	463,919	1,488,297	2,089,652		2,089,652	(360,082)	1,729,570			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,372,906	1,652,752	6,279,192	13,304,850		13,304,850	(334,738)	12,970,112			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(11,017)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(450,056)	30		9
10	Interest and Other Investment Income	(4,744)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(373)	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	(5,244)	24		19
20	Contributions	(10,875)	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	(20,598)	21		24
25	Fund Raising, Advertising and Promotional	(41,869)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,508)	20		28
29	Other-Attach Schedule	(485,119)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,031,403)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	696,665		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 696,665		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (334,738)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

ID#

0045534

Report Period Beginning:

01/01/11

Ending:

12/31/11

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Patient Needs	\$ (41,049)	10	1
2	Patient Clothing	(8,239)	10	2
3	Bank Charges	(27,333)	21	3
4	COPE Dues	(5,113)	20	4
5	Building Company Accounting Fees	(10,550)	19	5
6	Building Company Legal Fees	(250)	19	6
7	Building Company Licenses	(309)	20	7
8	Non- Allowable Management Fees	(227,077)	43	8
9	Annual Report	(309)	20	9
10	Non Reimbursable Salary	(114,730)	43	10
11	Capitalized R&M	(4,056)	06	11
12	Non-Allowable Legal	(4,938)	19	12
13	Building Company Amortization	(9,033)	31	13
14	Building Company Professional Fees	(67)	19	14
15	Records Copies	(295)	10	15
16	Jury Duty Income	(69)	10	16
17	Non-Allowable Interest	(17,830)	32	17
18	Community Relations	(16,644)	43	18
19	Discounts	(26)	21	19
20	Non - Allowable Travel	(1,631)	43	20
21	Prior Period Professional Fee	(9,878)	19	21
22	Additional R&M	14,306	06	22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(485,119)		49

ID#

0045534

Report Period Beginning:

01/01/11

Ending:

12/31/11

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
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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

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		
				Forest Villa Property, LLC		Building Co.

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	\$ 1,883,384	Forest Villa Property, LLC	100.00%	\$	(1,883,384)	1
2	V	32	Interest	4,669	Forest Villa Property, LLC	100.00%	1,017,550	1,012,881	2
3	V	19	Accounting Fees		Forest Villa Property, LLC	100.00%	10,550	10,550	3
4	V	36	MIP Insurance		Forest Villa Property, LLC	100.00%	85,508	85,508	4
5	V	26	Insurance Expense		Forest Villa Property, LLC	100.00%	17,252	17,252	5
6	V	33	Real Estate Taxes		Forest Villa Property, LLC	100.00%	491,377	491,377	6
7	V	20	License Fees		Forest Villa Property, LLC	100.00%	309	309	7
8	V	19	Professional Fees		Forest Villa Property, LLC	100.00%	67	67	8
9	V	30	Depreciation Expense		Forest Villa Property, LLC	100.00%	964,541	964,541	9
10	V	31	Amortization		Forest Villa Property, LLC	100.00%	9,033	9,033	10
11	V	19	Legal Fee		Forest Villa Property, LLC	100.00%	250	250	11
12	V								12
13	V								13
14	Total			\$ 1,888,053			\$ 2,596,437	\$ * 708,384	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.

☒ X

 YES

☐ NO

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

1		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%	\$ 2,182	\$	2,182 15
16	V	6	REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	8,676		8,676 16
17	V	17	ADMIN. - NON-OWNER		NUCARE SERVICES CORP.	100.00%	13,673		13,673 17
18	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	23,857		23,857 18
19	V	20	FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	1,024		1,024 19
20	V	21	CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	145,252		145,252 20
21	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	261		261 21
22	V	25	ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	608		608 22
23	V	26	INSURANCE		NUCARE SERVICES CORP.	100.00%	680		680 23
24	V	27	EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	46,006		46,006 24
25	V	30	DEPRECIATION		NUCARE SERVICES CORP.	100.00%	7,846		7,846 25
26	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	2,349		2,349 26
27	V	33	REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	7,325		7,325 27
28	V	34	PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	386		386 28
29	V	35	EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	3,024		3,024 29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V	17	MANAGEMENT FEES	400,052					(400,052) 35
36	V								36
37	V								37
38	V								38
39	Total			\$ 400,052			\$ 263,150	\$ *	(136,902) 39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. - G. JENICH		NUCARE SERVICES CORP.	100.00%		\$	15
16	V	17	ADMIN. - B. CARR		NUCARE SERVICES CORP.	100.00%	8,548	8,548	16
17	V	17	ADMIN. - M. HARTMAN		NUCARE SERVICES CORP.	100.00%	116,135	116,135	17
18	V								18
19	V								19
20	V	27	EMP. BEN. - G. JENICH		NUCARE SERVICES CORP.	100.00%			20
21	V	27	EMP. BEN. - B. CARR		NUCARE SERVICES CORP.	100.00%	422	422	21
22	V	27	EMP. BEN. - M. HARTMAN		NUCARE SERVICES CORP.	100.00%	5,737	5,737	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 130,842	\$ * 130,842	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MINOR EQUIPMENT	\$	CLINICAL CONSULTING SERVICES, LLC	100.00%	\$ 250	\$ 250	15
16	V	10	CLINICAL SALARIES		CLINICAL CONSULTING SERVICES, LLC	100.00%	7,326	7,326	16
17	V	19	PROFESSIONAL FEES		CLINICAL CONSULTING SERVICES, LLC	100.00%			17
18	V	20	DUES, LICENSE & INSPECTION		CLINICAL CONSULTING SERVICES, LLC	100.00%	30	30	18
19	V	21	OFFICE WAGES		CLINICAL CONSULTING SERVICES, LLC	100.00%	14,198	14,198	19
20	V	21	OFFICE EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	957	957	20
21	V	24	CONTINUING EDUCATION / SEMINAR		CLINICAL CONSULTING SERVICES, LLC	100.00%	194	194	21
22	V	25	AUTO EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	277	277	22
23	V	27	PAYROLL TAXES		CLINICAL CONSULTING SERVICES, LLC	100.00%	74	74	23
24	V	27	OTHER EMPLOYEE BENEFITS		CLINICAL CONSULTING SERVICES, LLC	100.00%	854	854	24
25	V	30	DEPRECIATION		CLINICAL CONSULTING SERVICES, LLC	100.00%	114	114	25
26	V	32	INTEREST		CLINICAL CONSULTING SERVICES, LLC	100.00%	130	130	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V	17	MANAGEMENT FEES	30,063				(30,063)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 30,063			\$ 24,405	\$ * (5,658)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Workers Compensation	\$ 46,911	Diamond Insurance	40.00%	\$ 46,911	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 46,911			\$ 46,911	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	BARRY CARR	42.000%	CHEVY CHASE CORP. D/B/A BRONZEVILLE PARK NURSING & REH	CHICAGO	FOREST VILLA PROPERTY, LL	LINCOLNWOOD	BUILDING CO.	1
2	DAVID HARTMAN	10.000%	CALIFORNIA GARDENS CORP.	CHICAGO	CLINICAL CONSULTING SERV.	LINCOLNWOOD	CLINICAL CONSULTING	2
3	JANET HARRIS	4.750%	CLAREMONT EXTENDED HEALTHCARE, L.L.C.	BUFFALO GROVE	QUEST SERVICES CORP.	LINCOLNWOOD	MARKETING	3
4	JUDY HARRIS TRUST	12.625%	CLARIDGE IMPERIAL, LTD.	CHICAGO	DBD REHABILITAION SERV.	CHICAGO	PSYCHIATRIC SERVICE	4
5	MICHAEL HARRIS	17.625%	JACKSON CORP.	CHICAGO	JEM REHABILITATION SERV.	CHICAGO	PSYCHIATRIC SERVICE	5
6	ROBERT HARTMAN FAMILY TRUST	10.000%	MONROE CORP.	CHICAGO	JLR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	6
7	THE ROBERT & DEBRA HARTMAN FOUNDATION	3.000%	THE RENAISSANCE AT 87TH STREET, INC.	CHICAGO	SEASONS HOSPICE	PARK RIDGE	HOSPICE	7
8			THE RENAISSANCE AT HILLSIDE, INC.	HILLSIDE	KFT SERVICES, LLC	LINCOLNWOOD	MANAGEMENT CO.	8
9			THE RENAISSANCE AT MIDWAY, INC.	CHICAGO	7257 N. LINCOLN AVENUE, LLC	LINCOLNWOOD	BUILDING RENTAL	9
10			THE RENAISSANCE AT SOUTH SHORE, INC.	CHICAGO	NUCARE SERVICES	LINCOLNWOOD	BOOKEEPING / MANAGI	10
11			RENAISSANCE EAST	MESA, ARIZONA	DRAKE LOUIS ENTERPRISE, LI	LINCOLNWOOD	MANAGEMENT CO.	11
12			RENAISSANCE PARK SOUTH, LLC	CHICAGO	DIAMOND INSURANCE	NORHTBROOK	WORKERS COMP	12
13			RENAISSANCE VILLAGE AL	MESA, ARIZONA				13
14			RENAISSANCE VILLAGE IL	MESA, ARIZONA				14
15			RENAISSANCE WEST	MESA, ARIZONA				15
16			CLAREMONT-HANOVER PARK	HANOVER PARK				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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

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

Facility Name & ID Number Forest Villa Nrsg. & Rehab Ctr. # 0045534 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	17.65%	See Attached	13.83	34.58%	Mgmt. Fees	\$ 36,000	17-3	1
2	David Hartman	Owner	Administrative	10.00%	See Attached	0.71	1.78%	Salary	36,259	17-1	2
3	Mark Hartman	Relative	Administrative	0.00%	See Attached	10	25.00%	Alloc Sal	116,135	17-7	3
4	Barry Carr	Owner	Administrative	42.00%	See Attached	2.14	4.28%	Alloc Sal	8,548	17-7	4
5											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	\$ 196,942		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 Nrsg. & Rehab Ctr. # 0045534 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

Facility Name & ID Number Forest Villa Nrsg. & Rehab Ctr. # 0045534 Report Period Beginning: 01/01/11 Ending: 12/31/11

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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	UTILITIES	AVAIL. CENSUS DAYS	1,283,340	16	\$ 36,192	\$	77,380	\$ 2,182	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	1,283,340	16	143,887		77,380	8,676	2
3	17	ADMIN. - NON-OWNER	AVAIL. CENSUS DAYS	1,283,340	16	226,766	211,441	77,380	13,673	3
4	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,283,340	16	395,673		77,380	23,857	4
5	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	1,283,340	16	16,986		77,380	1,024	5
6	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	1,283,340	16	2,408,992	(706,320)	77,380	145,252	6
7	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,283,340	16	4,332		77,380	261	7
8	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	1,283,340	16	10,088		77,380	608	8
9	26	INSURANCE	AVAIL. CENSUS DAYS	1,283,340	16	11,273		77,380	680	9
10	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	1,283,340	16	763,008		77,380	46,006	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,283,340	16	130,120		77,380	7,846	11
12	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,283,340	16	38,953		77,380	2,349	12
13	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,283,340	16	121,491		77,380	7,325	13
14	34	PARKING LOT RENT	AVAIL. CENSUS DAYS	1,283,340	16	6,400		77,380	386	14
15	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,283,340	16	50,154		77,380	3,024	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,364,315	\$		\$ 263,150	25

Facility Name & ID Number Forest Villa Nrsg. & Rehab Ctr. # 0045534 Report Period Beginning: 01/01/11 Ending: 12/31/11

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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	ADMIN. - G. JENICH	AVG. HOURS WORKED	10	5	50,000	50,000			1
2	17	ADMIN. - B. CARR	AVG. HOURS WORKED	10	4	40,000	40,000	2	8,548	2
3	17	ADMIN. - M. HARTMAN	AVG. HOURS WORKED	10	1	116,135	116,135	10	116,135	3
4										4
5										5
6	27	EMP. BEN. - G. JENICH	AVG. HOURS WORKED	10	5	2,471				6
7	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED	10	4	1,977		2	422	7
8	27	EMP. BEN. - M. HARTMAN	AVG. HOURS WORKED	10	1	5,737		10	5,737	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					\$ 216,319	\$ 206,135		\$ 130,842	25

Facility Name & ID Number Forest Villa Nrsg. & Rehab Ctr. # 0045534 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	6	MINOR EQUIPMENT	AVAIL. CENSUS DAYS	1,283,340	17	\$ 4,147	\$	77,380	\$ 250	1
2	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,283,340	17	121,500	121,500	77,380	7,326	2
3	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,283,340	17			77,380		3
4	20	DUES, LICENSE & INSPECTION	AVAIL. CENSUS DAYS	1,283,340	17	500		77,380	30	4
5	21	OFFICE WAGES	AVAIL. CENSUS DAYS	1,283,340	17	235,467	235,467	77,380	14,198	5
6	21	OFFICE EXPENSE	AVAIL. CENSUS DAYS	1,283,340	17	15,872		77,380	957	6
7	24	CONTINUING EDUCATION / SE	AVAIL. CENSUS DAYS	1,283,340	17	3,225		77,380	194	7
8	25	AUTO EXPENSE	AVAIL. CENSUS DAYS	1,283,340	17	4,586		77,380	277	8
9	27	PAYROLL TAXES	AVAIL. CENSUS DAYS	1,283,340	17	1,222		77,380	74	9
10	27	OTHER EMPLOYEE BENEFITS	AVAIL. CENSUS DAYS	1,283,340	17	14,168		77,380	854	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,283,340	17	1,896		77,380	114	11
12	32	INTEREST	AVAIL. CENSUS DAYS	1,283,340	17	2,164		77,380	130	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					\$ 404,746	\$ 356,967		\$ 24,405	25

Facility Name & ID Number Forest Villa Nrsg. & Rehab Ctr. # 0045534 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			\$	\$		\$ 46,911	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					\$	\$		\$ 46,911	25

Facility Name & ID Number Forest Villa Nrsg. & Rehab Ctr. # 0045534 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

Facility Name & ID Number Forest Villa Nrsg. & Rehab Ctr. # 0045534 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

Facility Name & ID Number Forest Villa Nrsg. & Rehab Ctr. # 0045534 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

Facility Name & ID Number Forest Villa Nrsg. & Rehab Ctr. # 0045534 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

Facility Name & ID Number Forest Villa Nrsg. & Rehab Ctr. # 0045534 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	HUD		X	Mortgage			\$	17,027,038			\$	1,017,550	1
2													2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	Bank of America		X	Line of Credit				2,402,012				52,720	6
7			X	Loan Advance				100,000					7
8	See Supplemental Schedule							700,000				2,479	8
9	TOTAL Facility Related						\$	20,229,050			\$	1,072,749	9
	B. Non-Facility Related*												
10	Interest Income		X									(4,744)	10
11	Judy Harris Trust	X										17,830	11
12	Interest Income- Building		X									(4,669)	12
13	See Supplemental Schedule											(17,830)	13
14	TOTAL Non-Facility Related						\$				\$	(9,413)	14
15	TOTALS (line 9+line14)						\$	20,229,050			\$	1,063,336	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 85,508 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.)

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					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term												7
	Working Capital												
8	Due to Shareholders						\$		\$ 700,000			\$	8
9	Allocated from NuCare											2,349	9
10	Allocated from Clinical Consulting											130	10
11													11
12													12
13													13
14	TOTAL Working Capital								700,000			2,479	14
	B. Non-Facility Related*												
15	Non Allowable interest	X					\$		\$			\$ (17,830)	15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related											(17,830)	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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	392,823	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	438,642	2
3. Under or (over) accrual (line 2 minus line 1).				\$	45,819	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	452,883	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	27,614	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ 771 For 2001 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	526,316	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2006	298,251	8		
		2007	340,137	9		
		2008	350,486	10		
		2009	374,118	11		
		2010	431,317	12		
2011 Accrual: \$431,317 X 1.05 = \$452,883						
Allocated From NuCare: \$7,325						

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Forest Villa Nrsg. & Rehab Ctr.</u>	COUNTY	<u>Cook</u>
---------------	--	--------	-------------

FACILITY IDPH LICENSE NUMBER 0045534

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>10-30-317-030-0000</u>	<u>Long Term Care Property</u>	\$ <u>180,130.64</u>	\$ <u>180,130.64</u>
2.	<u>10-30-317-044-0000</u>	<u>Long Term Care Property</u>	\$ <u>251,186.75</u>	\$ <u>251,186.75</u>
3.	<u>10-27-319-028-0000</u>	<u>Home Office Allocation</u>	\$ <u>81,875.48</u>	\$ <u>4,443.07</u>
4.	<u>10-27-319-028-0000</u>	<u>Home Office Allocation</u>	\$ <u>81,875.48</u>	\$ <u>246.84</u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u>595,068.35</u>	\$ <u>436,007.30</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: *Payment information from the Internet* or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Forest Villa Nrsg. & Rehab Ctr.</u>	COUNTY	<u>Cook</u>
---------------	--	--------	-------------

FACILITY IDPH LICENSE NUMBER 0045534

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,000

B. General Construction Type: Exterior Brick Frame Steel Number of Stories

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Allocated from 7257 N. Lincoln & Clinical Consulting			\$ 9,165	1
2	Land		2009	2,330,768	2
3	TOTALS			\$ 2,339,933	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	212		2009	1964	\$ 9,756,249	\$ 509,418	35	\$ 325,994	\$ (183,424)	\$ 739,403	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2002	263,767		20	11,810	11,810	158,174	9
10	Various			2003	126,077		20	5,828	5,828	93,454	10
11	Various			2004	63,667		20	3,911	3,911	34,713	11
12	Various			2005	70,739		20	5,594	5,594	37,152	12
13	Various			2006	32,275		20	2,873	2,873	16,095	13
14	Various			2007	33,549		20	2,815	2,815	13,002	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		1,968,465	252,015		98,423	(153,592)		67
68	Related Party Allocations (Pages 12H & 12I)		174,646	5,780		4,975	(805)	32,230	68
69	Financial Statement Depreciation			152,228			(152,228)		69
70	TOTAL (lines 4 thru 69)		\$ 12,489,434	\$ 919,441		\$ 462,222	\$ (457,219)	\$ 1,124,223	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Forest Villa Nrsg. & Rehab Ctr.

0045534

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 12,489,434	\$ 919,441		\$ 462,222	\$ (457,219)	\$ 1,124,223	1
2	16 Pcs Drapes	2008	5,479		20	548	548	2,192	2
3	Water Heater	2008	7,516		20	626	626	2,453	3
4	Change Laminate On 15 Doors	2008	3,155		20	158	158	592	4
5	Replace 3 Places On Roof	2008	6,300		20	315	315	1,181	5
6	Landscaping Work	2008	5,500		20	367	367	1,344	6
7	10 Recessed Ceiling Lights And 2 Switches	2008	1,200		20	60	60	200	7
8	Laminate 12 Doors	2008	2,658		20	133	133	432	8
9	Generator	2008	2,584		20	129	129	409	9
10	Fireproofing Job	2009	3,900		20	557	557	1,579	10
11	Fencing Materials Around A/C Units	2009	4,652		20	233	233	620	11
12	Pulled Cables For Base Stations	2009	3,977		20	199	199	497	12
13	Parking Lot Repairs	2009	29,000		20	2,900	2,900	6,767	13
14	Tadiran Ipx500 Telephone System	2009	25,275		20	2,528	2,528	6,529	14
15	Tadiran Ipx500 Telephone System	2009	25,275		20	2,528	2,528	6,319	15
16	56 Additional Ports; 64 Port Authorization Flexset Telephones; 1 U	2009	13,985		20	1,399	1,399	3,496	16
17	1 Commercial Water Softener	2009	3,150		20	263	263	656	17
18	Roof Repairs	2009	4,200		20	210	210	455	18
19	Relocate Pump Booster	2009	4,261		20	213	213	462	19
20	Boiler Room Work	2009	5,000		20	250	250	688	20
21	Structural Engineer Services- For Ramp	2010	3,952		20	198	198	379	21
22	Rm 200-20610 Boxes Rubbercove Base, 50 Cases Vct, 2 Buckets G	2010	3,130		20	157	157	274	22
23	Wall Coverings, Tile Planks	2010	10,374		20	519	519	994	23
24	Roof Replacement With New Modified Bitumen System	2010	4,450		20	223	223	315	24
25	Asphalt Repairs	2010	6,300		20	630	630	788	25
26	Room Signs, Ada Signage	2010	9,112		20	847	847	988	26
27	Remove Old Gravel Stop Edge Flashing And Install New Custom	2011	3,450		20	173	173	173	27
28	67 Custom Plaque Signs 2 Slots For Name Slide, Custome Plaque S	2011	3,634		20	273	273	273	28
29	Sealcoat Approx 42359 Sq Ft 1 Coat Only, Sweep And Blow Loose	2011	28,125		20	1,172	1,172	1,172	29
30	Remove And Replace Broken Concrete 52 Linear Ft Long. Fill Wi	2011	5,800		20	33	33	33	30
31	Exhaust Vents And Motors	2011	3,934		20	66	66	66	31
32	Kithchen And 2Nd Floor Doors	2011	4,056		20				32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,732,820	\$ 919,441		\$ 480,124	\$ (439,317)	\$ 1,166,547	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 12,732,820	\$ 919,441		\$ 480,124	\$ (439,317)	\$ 1,166,547	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
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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)		\$ 12,732,820	\$ 919,441		\$ 480,124	\$ (439,317)	\$ 1,166,547	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 12,732,820	\$ 919,441		\$ 480,124	\$ (439,317)	\$ 1,166,547	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)		\$ 12,732,820	\$ 919,441		\$ 480,124	\$ (439,317)	\$ 1,166,547	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 and Improvement Costs-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	Totals from Page 12D, Carried Forward		\$12,732,820	\$919,441		\$480,124	\$(439,317)	\$1,166,547	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)		\$12,732,820	\$919,441		\$480,124	\$(439,317)	\$1,166,547	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 and Improvement Costs-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			208,941			(208,941)		10
11	2011	47,926	1,198	20	2,396	1,198		11
12	2011	459,687	15,323	20	22,984	7,661		12
13	2011	10,280	734	20	514	(220)		13
14	2011	322,430	10,748	20	16,122	5,374		14
15	2011	912,684	11,701	20	45,634	33,933		15
16	2011	67,394	3,370	20	3,370	(0)		16
17	2011	21,414		20	1,071	1,071		17
18	2011	126,650		20	6,333	6,333		18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34								34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 Building Company Information Continued		\$	\$		\$	\$	\$	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 (12F & 12G lines 1 thru 33)		\$ 1,968,465	\$ 252,015		\$ 98,423	\$ (153,592)	\$	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 Nrsg. & Rehab Ctr.

0045534

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated From 7257 N. Lincoln Ave LLC	2004	78,143	2,004	35	2,233	229	18,140	3
4	Allocated From Clinical Consulting Services	2004	4,341	111	35	124	13	1,008	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From 7257 N. Lincoln Ave LLC	2004	1,553		20	78	78	582	9
10	Allocated From 7257 N. Lincoln Ave LLC	2005	7,124	54	20	460	406	2,901	10
11									11
12	Allocated From Clinical Consulting Services	2004	86		20	4	4	32	12
13	Allocated From Clinical Consulting Services	2005	396	3	20	26	23	161	13
14									14
15	Allocated From NuCare Services Corp.	2003	706	31	20	35	4	287	15
16	Allocated From NuCare Services Corp.	2004	56,350	623	20	718	95	5,535	16
17	Allocated From NuCare Services Corp.	2005	850	37	20	43	6	291	17
18	Allocated From NuCare Services Corp.	2006	1,153	50	20	58	8	309	18
19	Allocated From NuCare Services Corp.	2008	1,215	53	20	61	8	198	19
20	Allocated From NuCare Services Corp.	2009	19,561	2,676	20	978	(1,698)	2,552	20
21	Allocated From NuCare Services Corp.	2010	3,006	131	20	150	19	227	21
22	Allocated From NuCare Services Corp.	2011	162	7	20	7		7	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Related Party Information Continued								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
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		\$174,646	\$5,780		\$4,975	\$(805)	\$32,230	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,476,998	\$201,899	\$170,203	\$(31,696)	10	\$631,918	71
72	Current Year Purchases	158,429	226	20,096	19,870	10	20,096	72
73	Fully Depreciated Assets	389,775		122	122	10	389,775	73
74								74
75	TOTALS	\$2,025,201	\$202,125	\$190,420	\$(11,705)		\$1,041,789	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Conversion Van	2007	\$7,200	\$	882	\$882	5	\$4,995	76
77		Allocated from NuCare	2011	534	23	107	84	5	151	77
78										78
79										79
80	TOTALS			\$7,734	\$23	\$989	\$966		\$5,146	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$17,105,688	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$1,121,589	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$671,533	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(450,056)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,213,482	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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	Allocated from NuCare				386			5
6								6
7	TOTAL				\$ 386			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: \$ 3,024
- 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	Facility	Ford/F-150 Crew Cab/2010	\$	6,948	17
18					18
19					19
20					20
21	TOTAL		\$	6,948	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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

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

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 240,083	\$		\$ 240,083	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			150,854			150,854	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			427,147			427,147	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				375,261		375,261	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental			6,062		121,598	88,658		216,318	13
14	TOTAL			\$ 6,062		\$ 939,682	\$ 463,919		\$ 1,409,663	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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 389,941	\$ 757,629	1
2	Cash-Patient Deposits	2,037	2,037	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,781,760	3,781,760	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	141,524	149,935	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,560,262	2,386,256	8
9	Other(specify): See Attached Schedule	5,962	948,524	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,881,486	\$ 8,026,141	10
	B. Long-Term Assets			
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	830,595	2,698,110	15
16	Equipment, at Historical Cost	997,952	2,533,148	16
17	Accumulated Depreciation (book methods)	(1,212,585)	(3,446,559)	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): See Attached Schedule		297,337	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 615,962	\$ 14,121,940	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,497,448	\$ 22,148,081	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,156,395	\$ 1,156,396	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	800,000	800,000	29
30	Accrued Salaries Payable	633,994	633,994	30
31	Accrued Taxes Payable (excluding real estate taxes)	39,344	39,344	31
32	Accrued Real Estate Taxes(Sch.IX-B)		452,883	32
33	Accrued Interest Payable		84,426	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,632,207	1,660,787	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,261,940	\$ 4,827,830	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,402,012	2,402,012	39
40	Mortgage Payable		17,027,038	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,402,012	\$ 19,429,050	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,663,952	\$ 24,256,880	46
47	TOTAL EQUITY(page 18, line 24)	\$ (166,504)	\$ (2,108,799)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,497,448	\$ 22,148,081	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$1,080,388	1
2	Restatements (describe):		2
3	Part B Co-Insurance Write off	(9,614)	3
4	Medicare ADJ	(2,998)	4
5	Rounding	(3)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$1,067,773	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,234,277)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$(1,234,277)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$(166,504)	24 *

* 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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,593,902	1
2	Discounts and Allowances for all Levels	(857,603)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,736,299	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,988,004	6
7	Oxygen	8,684	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,996,688	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	976,413	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	54,862	19
20	Radiology and X-Ray	18,301	20
21	Other Medical Services	241,653	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,291,229	23
	D. Non-Operating Revenue		
24	Contributions	250	24
25	Interest and Other Investment Income***	4,744	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,994	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	41,363	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 41,363	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,070,573	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,654,361	31
32	Health Care	4,669,843	32
33	General Administration	2,777,884	33
	B. Capital Expense		
34	Ownership	2,113,110	34
	C. Ancillary Expense		
35	Special Cost Centers	1,769,745	35
36	Provider Participation Fee	319,907	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,304,850	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,234,277)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,234,277)	43

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

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

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

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

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	1,885	2,086	\$ 100,317	\$ 48.09	1
2	Assistant Director of Nursing	2,320	2,461	102,579	41.68	2
3	Registered Nurses	38,476	42,217	1,251,699	29.65	3
4	Licensed Practical Nurses	28,342	30,811	761,021	24.70	4
5	CNAs & Orderlies	10,883	109,696	1,325,158	12.08	5
6	CNA Trainees					6
7	Licensed Therapist	160	160	6,062	37.89	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,414	4,947	109,734	22.18	10
11	Social Service Workers	4,119	4,655	78,348	16.83	11
12	Dietician	2,106	2,472	69,882	28.27	12
13	Food Service Supervisor					13
14	Head Cook	6,480	7,440	99,183	13.33	14
15	Cook Helpers/Assistants	20,654	23,046	218,147	9.47	15
16	Dishwashers					16
17	Maintenance Workers	5,258	5,699	109,886	19.28	17
18	Housekeepers	23,184	25,227	239,827	9.51	18
19	Laundry	7,035	8,121	77,082	9.49	19
20	Administrator	1,824	2,312	100,568	43.50	20
21	Assistant Administrator	1,558	1,589	23,775	14.96	21
22	Other Administrative	2,184	2,080	50,781	24.41	22
23	Office Manager	1,916	2,757	114,246	41.44	23
24	Clerical	11,074	12,482	290,832	23.30	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	33,340	3,619	92,249	25.49	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	5,251	5,407	151,530	28.02	33
34	TOTAL (lines 1 - 33)	212,463	299,284	\$ 5,372,906 *	\$ 17.95	34

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	350	\$ 16,468	01-03	35
36	Medical Director	Monthly	81,750	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	17,258	10-03	38
39	Pharmacist Consultant	Monthly	6,028	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	70	4,077	12-03	45
46	Other(specify)				46
47	Geriatric Unit Director	Monthly	50,040	10-03	47
48	Therapy	24	1,181	10a-03	48
49	TOTAL (lines 35 - 48)	444	\$ 176,802		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	653	\$ 32,660	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	653	\$ 32,660		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number		Forest Villa Nrsg. & Rehab Ctr.		STATE OF ILLINOIS		Report Period Beginning:		01/01/11		Page 21		Ending:		12/31/11									
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									
Jacqueline, Gully		Administrator		0.00%		\$ 33,285		Workers' Compensation Insurance		\$ 79,229		IDPH License Fee		\$ 2,405									
Donald-Jay Andrews		Administrator		0.00%		11,960		Unemployment Compensation Insurance		48,116		Advertising: Employee Recruitment		3,988									
Jan Kaval		Administrator		0.00%		6,244		FICA Taxes		410,798		Health Care Worker Background Check											
Amanda Andrews		Administrator		0.00%		49,078		Employee Health Insurance		284,010		(Indicate # of checks performed 566)		8,645									
David Hartman		Executive Director		10.00%		36,259		Employee Meals		74,022		Patient Background Checks											
Kathleen Brander		Dir. Reg Mgmt		0.00%		14,523		Illinois Municipal Retirement Fund (IMRF)*				Dues & Subscriptions		18,163									
See Supplemental Schedule						23,775		401 K Matching		9,187		Advertising & Promotions		43,377									
TOTAL (agree to Schedule V, line 17, col. 1)								Other Employee Benefits				39,714				Licenses & Inspections				15,329			
(List each licensed administrator separately.)				\$ 175,124				Dental Insurance				10,540				Allocated from NuCare				1,024			
B. Administrative - Other								Vision Insurance				64				See Supplemental Schedule				30			
Description				Amount												Less: Public Relations Expense (							
NuCare Services -Administrative Fee				\$ 400,052												Non-allowable advertising				(41,869)			
Clinical Consulting - Administrative Fee				30,063												Yellow page advertising				(1,508)			
Michael Harris-Management Fees				36,000																			
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 466,115				TOTAL (agree to Schedule V, line 22, col.8)				\$ 955,680				TOTAL (agree to Sch. V, line 20, col. 8)				\$ 49,584			
(Attach a copy of any management service agreement)								E. Schedule of Non-Cash Compensation Paid to Owners or Employees								G. Schedule of Travel and Seminar**							
C. Professional Services								Description				Line #		Amount		Description				Amount			
Vendor/Payee		Type				Amount										Out-of-State Travel		\$					
See Attached		Legal				\$ 103,155																	
Frost, Ruttenberg & Rothblatt		Accounting				28,215																	
Personnel Planners		Unemployment Consultant				1,970																	
Innovative Therapy Partners		MDS Consulting				4,000										In-State Travel							
CDW Computer Centers		Computer Services				2,890																	
Emdeon		Computer Services				488																	
Giftrap		Computer Services				2,565																	
HDSI		Computer Services				4,365										Seminar Expense		13,720					
MDI Achieve		Computer Services				25,046										Allocated from NuCare		261					
PSD Solutions		Computer Services				6,710										Allocated from Clinical Consulting		194					
Achieve Accreditation		Survey Consulting				4,090																	
See Supplemental Schedule						23,580										Entertainment Expense (							
TOTAL (agree to Schedule V, line 19, column 3)								TOTAL				\$		(agree to Sch. V, line 24, col. 8)				\$ 14,175					
(If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 207,075																			
* Attach copy of IMRF notifications																**See instructions.							
SEE ACCOUNTANTS' COMPILATION REPORT																							

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

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\$20,543

(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.

\$326

Line10-02

(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?

YESXNO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YESNOX

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.

\$319,907

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.

\$74,022

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% line 14

d. Have vehicle usage logs been maintained?

No

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$N/A

(17) Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.

SEE ACCOUNTANTS' COMPILATION REPORT