		FOR BHF USE					

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0040022

Facility Name: California Gardens N & Rehab Ctr

Address: 2829 South California Blvd (Number) Chicago (City) 60608 (Zip Code)

County: Cook

Telephone Number: (773) 847-8061 **Fax #** (773) 847-1603

HFS ID Number:

Date of Initial License for Current Owners: 07/01/1994

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Kimberley A. Waite, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	297	Skilled (SNF)	297	108,405	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	297	TOTALS	297	108,405	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			6,179	6,179	8
9	SNF/PED					9
10	ICF	93,292	759	3,707	97,758	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	93,292	759	9,886	103,937	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.88%

D. How many bed-hold days during this year were paid by the Department?
2,550 (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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 07/01/1994

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/1994 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 297 and days of care provided 5,654

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger: Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	411,624	101,663	13,883	527,170		527,170		527,170			1
2	Food Purchase		492,083		492,083	(1,719)	490,364	(46)	490,318			2
3	Housekeeping	7,628	49,766	484,344	541,738		541,738		541,738			3
4	Laundry		23,398	7,809	31,207		31,207		31,207			4
5	Heat and Other Utilities			252,077	252,077		252,077	3,380	255,457			5
6	Maintenance	240,611	67,222	174,205	482,038		482,038	5,930	487,968			6
7	Other (specify):*											7
8	TOTAL General Services	659,863	734,132	932,318	2,326,313	(1,719)	2,324,594	9,264	2,333,858			8
	B. Health Care and Programs											
9	Medical Director			43,500	43,500		43,500		43,500			9
10	Nursing and Medical Records	4,050,099	457,527	22,657	4,530,283		4,530,283	(115,489)	4,414,794			10
10a	Therapy	74,615	11,836		86,451		86,451		86,451			10a
11	Activities	82,268	17,964	2,388	102,620		102,620		102,620			11
12	Social Services	146,668		1,595	148,263		148,263		148,263			12
13	CNA Training											13
14	Program Transportation	105,841		7,245	113,086		113,086		113,086			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,459,491	487,327	77,385	5,024,203		5,024,203	(115,489)	4,908,714			16
	C. General Administration											
17	Administrative	160,231		839,782	1,000,013		1,000,013	(801,918)	198,095			17
18	Directors Fees											18
19	Professional Services			141,581	141,581	(4,519)	137,062	(140)	136,922			19
20	Dues, Fees, Subscriptions & Promotions			107,766	107,766		107,766	(57,659)	50,107			20
21	Clerical & General Office Expenses	270,812	67,193	1,547,445	1,885,450		1,885,450	(1,244,502)	640,948			21
22	Employee Benefits & Payroll Taxes			992,180	992,180	1,719	993,899		993,899			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,592	14,592		14,592	772	15,364			24
25	Other Admin. Staff Transportation			657	657		657	1,827	2,484			25
26	Insurance-Prop.Liab.Malpractice			548,887	548,887		548,887	16,945	565,832			26
27	Other (specify):*							56,896	56,896			27
28	TOTAL General Administration	431,043	67,193	4,192,890	4,691,126	(2,800)	4,688,326	(2,027,778)	2,660,548			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,550,397	1,288,652	5,202,593	12,041,642	(4,519)	12,037,123	(2,134,003)	9,903,120			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number California Gardens N & Rehab Ctr #0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			115,766	115,766		115,766	286,967	402,733			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			59,713	59,713		59,713	672,331	732,044			32
33	Real Estate Taxes					4,519	4,519	459,727	464,246			33
34	Rent-Facility & Grounds			2,568,965	2,568,965		2,568,965	(2,568,361)	604			34
35	Rent-Equipment & Vehicles			13,551	13,551		13,551	5,739	19,290			35
36	Other (specify):*							69,415	69,415			36
37	**TOTAL Ownership**			2,757,995	2,757,995	4,519	2,762,514	(1,074,181)	1,688,333			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	116,182	332,950	516,654	965,786		965,786		965,786			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			162,608	162,608		162,608		162,608			42
43	Other (specify):*	62,496		174,447	236,943		236,943	(236,943)				43
44	**TOTAL Special Cost Centers**	178,678	332,950	853,709	1,365,337		1,365,337	(236,943)	1,128,394			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,729,075	1,621,602	8,814,297	16,164,974		16,164,974	(3,445,127)	12,719,847			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	(7,800)	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	(51,231)	30		9
10	Interest and Other Investment Income	(43,217)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(36)	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	(8,068)	21		18
19	Entertainment	(525)	24		19
20	Contributions	(21,700)	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	(1,451,979)	21		24
25	Fund Raising, Advertising and Promotional	(26,436)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(460,638)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,071,630)		$	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)	(1,373,496)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,373,496)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (3,445,127)		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

California Gardens N & Rehab Ctr

ID# 0040022

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Jury Duty Income	$ (69)	10	1
2	Records Copies	(854)	10	2
3	Veterans Expenses	(120,910)	10	3
4	Patient Needs	(13,247)	10	4
5	Patient Clothing	(19,052)	10	5
6	Bank Charges	(24,725)	21	6
7	Building Company Professional Fees	(11,080)	19	7
8	Building Company Amortization	(6,573)	36	8
9	Building Company Miscellaneous Liceses & Taxes	(6,866)	20	9
10	Building Company Bank Fees	(396)	21	10
11	Web Media	(25)	21	11
12	Non-Allowable Legal	(13,300)	19	12
13	COPE Dues	(10,997)	20	13
14	Annual Report	(325)	20	14
15	Non-Allowable Travel	(6)	25	15
16	Non-Allowable Semianr	(425)	24	16
17	Additional R&M	5,494	06	17
18	Food Rebate	(10)	02	18
19	Phone Income	(329)	21	19
20	Director of Guest Services Salary	(29,021)	43	20
21	Marketing Salary	(33,475)	43	21
22	Quest Management Fees	(174,447)	43	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**	(460,638)		49

California Gardens N & Rehab Ctr

ID# 0040022

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(46)											(46)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			3,380									3,380	5
6	Maintenance	(2,306)		8,236									5,930	6
7	Other (specify):*													7
8	**TOTAL General Services**	(2,352)		11,616									9,264	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(154,132)					38,643						(115,489)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(154,132)					38,643						(115,489)	16
	C. General Administration													
17	Administrative			(754,584)	16,562		(63,896)						(801,918)	17
18	Directors Fees													18
19	Professional Services	(24,380)	11,080	13,117			43						(140)	19
20	Fees, Subscriptions & Promotions	(66,324)	6,866	1,756			43						(57,659)	20
21	Clerical & General Office Expenses	(1,485,522)	396	208,850			31,774						(1,244,502)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(950)		1,503			219						772	24
25	Other Admin. Staff Transportation	(6)		1,530			303						1,827	25
26	Insurance-Prop.Liab.Malpractice		14,791	2,154									16,945	26
27	Other (specify):*			46,459	670		9,767						56,896	27
28	**TOTAL General Administration**	(1,577,182)	33,133	(479,214)	17,232		(21,747)						(2,027,778)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,733,666)	33,133	(467,598)	17,232		16,896						(2,134,003)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(51,231)	327,669	10,341			188						286,967	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(43,217)	710,534	4,750			264						672,331	32
33	Real Estate Taxes		450,465	9,262									459,727	33
34	Rent-Facility & Grounds		(2,568,782)	421									(2,568,361)	34
35	Rent-Equipment & Vehicles			5,739									5,739	35
36	Other (specify):*	(6,573)	75,988										69,415	36
37	**TOTAL Ownership**	(101,021)	(1,004,126)	30,515			452						(1,074,181)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(236,943)											(236,943)	43
44	**TOTAL Special Cost Centers**	(236,943)											(236,943)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(2,071,630)	(970,993)	(437,083)	17,232		17,348						(3,445,127)	45

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				California Gardens Associates		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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 2,568,782	California Gardens Associates	100.00%	$	$ (2,568,782)	1
2	V	32	Interest	311	California Gardens Associates	100.00%	710,845	710,534	2
3	V	19	Professional Fees		California Gardens Associates	100.00%	11,080	11,080	3
4	V	30	Depreciation		California Gardens Associates	100.00%	327,669	327,669	4
5	V	36	Amortization		California Gardens Associates	100.00%	6,573	6,573	5
6	V	33	Real Estate Tax		California Gardens Associates	100.00%	450,465	450,465	6
7	V	26	Property & Liability Insurance		California Gardens Associates	100.00%	14,791	14,791	7
8	V	20	Misc Licenses & Taxes		California Gardens Associates	100.00%	6,866	6,866	8
9	V	36	MIP Expenses		California Gardens Associates	100.00%	69,415	69,415	9
10	V	21	Bank Fees		California Gardens Associates	100.00%	396	396	10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,569,093			$ 1,598,100	$ * (970,993)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	NUCARE SERVICES CORP.	100.00%	$ 3,380	$ 3,380	15
16	V	6	REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	8,236	8,236	16
17	V	17	ADMIN. - NON-OWNER		NUCARE SERVICES CORP.	100.00%	21,301	21,301	17
18	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	13,117	13,117	18
19	V	20	FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	1,756	1,756	19
20	V	21	CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	208,850	208,850	20
21	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	1,503	1,503	21
22	V	25	ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	1,530	1,530	22
23	V	26	INSURANCE		NUCARE SERVICES CORP.	100.00%	2,154	2,154	23
24	V	27	EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	46,459	46,459	24
25	V	30	DEPRECIATION		NUCARE SERVICES CORP.	100.00%	10,341	10,341	25
26	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	4,750	4,750	26
27	V	33	REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	9,262	9,262	27
28	V	34	PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	421	421	28
29	V	35	EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	5,739	5,739	29
30	V								30
31	V	17	MANAGEMENT FEES	775,885	NUCARE SERVICES CORP.	100.00%		(775,885)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 775,885			$ 338,802	$ * (437,083)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. - R. HARTMAN		NUCARE SERVICES CORP.	100.00%	7,073	$ 7,073	15
16	V	17	ADMIN. - G. JENICH		NUCARE SERVICES CORP.	100.00%	9,489	9,489	16
17	V								17
18	V								18
19	V								19
20	V	27	EMP. BEN. - R. HARTMAN		NUCARE SERVICES CORP.	100.00%	286	286	20
21	V	27	EMP. BEN. - G. JENICH		NUCARE SERVICES CORP.	100.00%	384	384	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			$			$ 17,232	$ * 17,232	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Workers Compensation	$ 54,854	Diamond Insurance	100.00%	$ 54,854	$	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			$ 54,854			$ 54,854	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	CLINICAL SALARIES	$	CLINICAL CONSULTING SERVICES, LLC	100.00%	$ 38,643	$ 38,643	15
16	V	19	PROFESSIONAL FEES		CLINICAL CONSULTING SERVICES, LLC	100.00%	43	43	16
17	V	20	DUES, LICENSE & INSPECTION		CLINICAL CONSULTING SERVICES, LLC	100.00%	43	43	17
18	V	21	OFFICE WAGES		CLINICAL CONSULTING SERVICES, LLC	100.00%	28,231	28,231	18
19	V	21	OFFICE EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	3,543	3,543	19
20	V	24	CONTINUING EDUCATION / SEMINAR		CLINICAL CONSULTING SERVICES, LLC	100.00%	219	219	20
21	V	25	AUTO EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	303	303	21
22	V	27	PAYROLL TAXES		CLINICAL CONSULTING SERVICES, LLC	100.00%	4,600	4,600	22
23	V	27	OTHER EMPLOYEE BENEFITS		CLINICAL CONSULTING SERVICES, LLC	100.00%	5,167	5,167	23
24	V	30	DEPRECIATION		CLINICAL CONSULTING SERVICES, LLC	100.00%	188	188	24
25	V	32	INTEREST		CLINICAL CONSULTING SERVICES, LLC	100.00%	264	264	25
26	V								26
27	V	17	MANAGEMENT FEES	63,896	CLINICAL CONSULTING SERVICES, LLC	100.00%		(63,896)	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			$ 63,896			$ 81,244	$ * 17,348	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	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

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Robert Hartman	Owner	Administrative	55.75%	See Attached	1.77	3.54%	Alloc Salary	$ 7,073	17-7	1
2	David Hartman	Relative	Administrative	000%	See Attached	1.05	2.63%				2
3	Gerry Jenich	Owner	Administrative	5.00%	See Attached	1.90	4.75%	Alloc Salary	9,489	17-7	3
4											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	$ 16,562		13

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

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

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS	1,226,110	16	$ 38,227	$	108,405	$ 3,380	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	1,226,110	16	93,156		108,405	8,236	2
3	17	ADMIN. - NON-OWNER	AVAIL. CENSUS DAYS	1,226,110	16	240,928	240,928	108,405	21,301	3
4	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,226,110	16	148,362		108,405	13,117	4
5	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	1,226,110	16	19,864		108,405	1,756	5
6	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	1,226,110	16	2,362,190	2,024,369	108,405	208,850	6
7	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,226,110	16	16,998		108,405	1,503	7
8	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	1,226,110	16	17,306		108,405	1,530	8
9	26	INSURANCE	AVAIL. CENSUS DAYS	1,226,110	16	24,362		108,405	2,154	9
10	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	1,226,110	16	525,475		108,405	46,459	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,226,110	16	116,967		108,405	10,341	11
12	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,226,110	16	53,729		108,405	4,750	12
13	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,226,110	16	104,761		108,405	9,262	13
14	34	PARKING LOT RENT	AVAIL. CENSUS DAYS	1,226,110	16	4,765		108,405	421	14
15	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,226,110	16	64,914		108,405	5,739	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,832,004	$ 2,265,297		$ 338,802	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED	20	16	80,000	80,000	2	7,073	1
2	17	ADMIN. - G. JENICH	AVG. HOURS WORKED	10	8	50,000	50,000	2	9,489	2
3										3
4										4
5										5
6	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	20	16	3,234		2	286	6
7	27	EMP. BEN. - G. JENICH	AVG. HOURS WORKED	10	8	2,021		2	384	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					$ 135,254	$ 130,000		$ 17,232	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Diamond Insurance
Street Address: 40 Slokie Blvd., Suite 105
City / State / Zip Code: Northbrook, IL 60062
Phone Number: (847) 599-1002
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Workers Compensation	Direct Allocation			$	$		$ 54,854	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					$	$		$ 54,854	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,226,110	16	$ 437,066	$ 437,066	108,405	38,643	1
2	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,226,110	16	484		108,405	43	2
3	20	DUES, LICENSE & INSPECTION	AVAIL. CENSUS DAYS	1,226,110	16	488		108,405	43	3
4	21	OFFICE WAGES	AVAIL. CENSUS DAYS	1,226,110	16	319,300	319,300	108,405	28,231	4
5	21	OFFICE EXPENSE	AVAIL. CENSUS DAYS	1,226,110	16	40,077		108,405	3,543	5
6	24	CONTINUING EDUCATION / SE	AVAIL. CENSUS DAYS	1,226,110	16	2,480		108,405	219	6
7	25	AUTO EXPENSE	AVAIL. CENSUS DAYS	1,226,110	16	3,430		108,405	303	7
8	27	PAYROLL TAXES	AVAIL. CENSUS DAYS	1,226,110	16	52,028		108,405	4,600	8
9	27	OTHER EMPLOYEE BENEFITS	AVAIL. CENSUS DAYS	1,226,110	16	58,440		108,405	5,167	9
10	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,226,110	16	2,132		108,405	188	10
11	32	INTEREST	AVAIL. CENSUS DAYS	1,226,110	16	2,985		108,405	264	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 918,910	$ 756,366		$ 81,244	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HUD Loan		X	Mortgage			$	$ 13,789,228			$ 710,845	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Shareholder Loan		X	Working Capital				2,868,197			59,713	6
7												7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 16,657,425			$ 770,558	9
	B. Non-Facility Related*											
10	Interest Income		X								(43,217)	10
11	Interest Income- Building Co.		X								(311)	11
12	Allocated From NuCare		X								4,750	12
13	See Supplemental Schedule										264	13
14	TOTAL Non-Facility Related						$	$			$ (38,514)	14
15	TOTALS (line 9+line14)						$	$ 16,657,425			$ 732,044	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 69,415 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15	Allocated From CCS		X				$	$			$ 264	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										264	20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab Ctr **#** 0040022 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.	$	342,361	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.)	$	396,007	2
3. Under or (over) accrual (line 2 minus line 1).	$	53,646	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	406,082	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.**	$	4,519	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** $ 14,755 **For** 00&06 **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.	$	464,247	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	370,920	8
2006	326,303	9
2007	322,819	10
2008	326,058	11
2009	386,745	12

2010 Accrual=386,745 X 1.05 = $406,082

Allocation from Nucare: $9,262

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME California Gardens N & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040022

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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-25-401-015-0000	Long Term Care Property	$ 386,744.93	$ 386,744.93
2.	10-27-319-028-0000	Home Office Allocation	$ 81,288.74	$ 6,468.34
3.	10-27-319-028-0000	Home Office Allocation	$ 81,228.74	$ 359.09
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 549,262.41	$ 393,572.36

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME California Gardens N & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040022

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 2009 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 2009.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 72,844 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

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

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

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] NO
If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	193,025	1987	$ 300,000	1
2	Alloc from 7257 N Lincoln			13,439	2
3	TOTALS	193,025		$ 313,439	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1981	4,471		20			205	9
10	Various			1982	2,319		20			222	10
11	Various			1983	10,829		20			1,580	11
12	Various			1984	1,410		20			277	12
13	Various			1985	17,805		20			492	13
14	Various			1986	22,863		20			6,764	14
15	Various			1987	40,100		20			13,868	15
16	Various			1988	2,787		20			2,787	16
17	Various			1989	3,024		20			1,348	17
18	Various			1990	8,652		20	397	397	4,290	18
19	Various			1991	3,892		20	195	195	1,946	19
20	Various			1993	24,138		20	1,207	1,207	12,069	20
21	Various			1994	8,195		20	410	410	4,098	21
22	Various			1995	17,230		20	862	862	13,494	22
23	Various			1996	46,848		20	2,342	2,342	33,492	23
24	Various			1997	70,702		20	3,482	3,482	48,380	24
25	Various			1998	33,854		20	1,693	1,693	21,239	25
26	Various			1999	103,092		20	5,155	5,155	59,185	26
27	Various			2000	194,600		20	9,730	9,730	105,052	27
28	Various			2001	75,921		20	3,796	3,796	36,267	28
29	Various			2002	45,162		20	3,674	3,674	31,183	29
30	Various			2003	55,404		20	3,522	3,522	36,170	30
31	Various			2004	32,888		20	1,913	1,913	12,835	31
32	Various			2005	23,434		20	2,414	2,414	13,151	32
33	Various			2006	22,990		20	3,212	3,212	13,972	33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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)		5,056,096	327,669		203,126	(124,543)	2,662,133	67
68	Related Party Allocations (Pages 12H & 12I)		255,853	8,011		10,254	2,243	43,306	68
69	Financial Statement Depreciation			28,054			(28,054)		69
70	TOTAL (lines 4 thru 69)		$ 6,184,559	$ 363,734		$ 257,382	$ (106,352)	$ 3,179,805	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,184,559	$ 363,734		$ 257,382	$ (106,352)	$ 3,179,805	1
2	Elevator Repairs	2008	6,857		20	343	343	714	2
3	Landscape Irrigation System	2009	19,897		20	1,327	1,327	1,990	3
4	Install New Solid State Door Operator And Linkage Arms	2009	9,221		20	461	461	922	4
5	P.T.O.T. Cabinet & Desk Laminate,Elevator Finish/Handrails	2009	15,980		20	1,598	1,598	2,797	5
6	1St Floor Corridor Signage	2009	4,146		20	415	415	553	6
7	Landscaping Design	2009	4,970		20	332	332	497	7
8	Concrete Main Entrance And Sidewalks	2009	5,450		20	364	364	545	8
9	Elevator Improvement	2009	2,900		20	145	145	157	9
10	Floor Work, Ceilings, Wall Work, Lighting	2009	212,688		20	10,634	10,634	18,610	10
11	Floor Work, Ceilings, Wall Work, Lighting	2009	145,278		20	7,264	7,264	11,501	11
12	Cove Base/Handrails/Sconces/Signage/Paint/Art	2010	59,811		20	5,981	5,981	5,981	12
13	Elevator Door Jam, Removed Comp. Processessing Unit And Repa	2010	3,794		20	348	348	348	13
14	1 Pvi Water Heater,	2010	17,265		20	1,199	1,199	1,199	14
15	2000 Lft Chair Rail 5/8" X 2 1/2"	2010	4,390		20	110	110	110	15
16	Service And Replace 19 Smoke Detectors; 1 Valve Tamper & Insta	2010	3,769		20	94	94	94	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,700,975	$ 363,734		$ 287,996	$ (75,738)	$ 3,225,823	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,700,975	$ 363,734		$ 287,996	$ (75,738)	$ 3,225,823	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,700,975	$ 363,734		$ 287,996	$ (75,738)	$ 3,225,823	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,700,975	$ 363,734		$ 287,996	$ (75,738)	$ 3,225,823	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,700,975	$ 363,734		$ 287,996	$ (75,738)	$ 3,225,823	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 6,700,975	$ 363,734		$ 287,996	$ (75,738)	$ 3,225,823	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,700,975	$ 363,734		$ 287,996	$ (75,738)	$ 3,225,823	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3		1977	4,708,760	327,669		176,340	(151,329)	2,534,434	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Various	2004	18,253		20	1,435	1,435	8,740	9
10	Various	2005	147,095		20	14,526	14,526	82,687	10
11	Interlocking Door Parts	2007	3,821		20	191	191	764	11
12	Clear Polish Wire Glass - 3 Rooms	2007	3,148		20	157	157	629	12
13	Clear Polish Wire Glass - 1 Room	2007	485		20	24	24	97	13
14	Cooling Tower	2007	36,990		20	1,850	1,850	7,399	14
15	2 Passenger Elevator	2007	6,721		20	336	336	1,344	15
16	Electrical Work	2007	17,065		20	853	853	3,413	16
17	Smoke Detectors and Standared Wire Bases	2007	3,509		20	175	175	701	17
18	Motor - Cooling Tower	2007	4,110		20	206	206	823	18
19	Tadiran IPx500 Telephone System	2008	21,467		20	2,147	2,147	6,441	19
20	Carpet; Armstrong Beckford	2008	7,103		20	355	355	1,065	20
21	Remote Annunciator Panel for Basment Generator	2008	3,852		20	193	193	579	21
22	Headend Installation and Home Run Wiring to Roof	2008	13,039		20	1,304	1,304	3,912	22
23	Change Heights of Outlets	2008	2,625		20	131	131	393	23
24	Video Monitoring System	2008	3,713		20	186	186	558	24
25	Outdoor Lighting	2008	8,415		20	421	421	1,263	25
26	CCTV to Monitor Floors	2008	3,469		20	173	173	519	26
27	Varieties of Burning Bushes	2008	8,175		20	409	409	1,227	27
28	Installation of Video Multiplexer Recorder	2008	2,710		20	136	136	408	28
29	Asphalt Paving Work	2008	4,350		20	218	218	654	29
30	Landscape Irrigation System	2008	18,000		20	900	900	2,700	30
31	New Elevator Door	2008	9,221		20	461	461	1,383	31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$ 5,056,096	$ 327,669		$ 203,126	$ (124,543)	$ 2,662,133	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated fron NuCare 7257 N Lincoln Ave	2004	114,584	2,938	35	3,274	336	23,326	3
4	Allocated from Clinical Consulting Srvs 7257 N. Lincoln Ave	2004	6,366	163	35	182	19	1,296	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from NuCare 7257 N Lincoln Ave	2005	10,446	455	20	674	219	3,580	9
10	Allocated from NuCare 7257 N Lincoln Ave	2004	2,277		20	114	114	740	10
11									11
12	Allocated from Clinical Consulting Srvs 7257 N. Lincoln Ave	2005	580	25	20	37	12	199	12
13	Allocated from Clinical Consulting Srvs 7257 N. Lincoln Ave	2004	127		20	6	6	41	13
14									14
15	Allocated from NuCare	2003	1,036	38	20	52	14	369	15
16	Allocated from NuCare	2004	21,025	767	20	1,053	286	7,063	16
17	Allocated from NuCare	2005	1,247	45	20	62	17	365	17
18	Allocated from NuCare	2006	1,690	62	20	85	23	369	18
19	Allocated from NuCare	2008	1,781	65	20	89	24	201	19
20	Allocated from NuCare	2009	90,286	3,292	20	4,514	1,222	5,645	20
21	Allocated from NuCare	2010	4,408	161	20	112	(49)	112	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 255,853	$ 8,011		$ 10,254	$ 2,243	$ 43,306	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,045,599	$ 81,545	$ 111,773	$ 30,228	10	$ 566,741	71
72	Current Year Purchases	93,204	8,656	2,521	(6,135)	10	2,521	72
73	Fully Depreciated Assets	256,993		377	377	10	256,993	73
74								74
75	TOTALS	$ 1,395,797	$ 90,201	$ 114,672	$ 24,471		$ 826,255	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1996 FORD WAGON	1997	$ 21,161	$	$	$	5	$ 21,160	76
77		Allocated From NuCare	2010	783	29	65	36	5	65	77
78										78
79										79
80	TOTALS			$ 21,944	$ 29	$ 65	$ 36		$ 21,225	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,432,155	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 453,964	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 402,733	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (51,231)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,073,304	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Storage Unit Rental				183			5
6	Allocated From Nucare (Parking Lot)				421			6
7	TOTAL				$ 604 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 19,290 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			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	
	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	$		$ 207,961	$		$ 207,961	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			121,741			121,741	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			181,738			181,738	4
5	Physician Care		visits							5
6	Dental Care	39 - 03	visits			15			15	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				207,396		207,396	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental			116,182		5,199	125,554		246,935	13
14	TOTAL			$ 116,182		$ 516,654	$ 332,950		$ 965,786	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

STATE OF ILLINOIS

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 400	$ 328,117	1
2	Cash-Patient Deposits	373	373	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,589,370	2,705,216	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	138,702	138,702	6
7	Other Prepaid Expenses	485,997	547,247	7
8	Accounts Receivable (owners or related parties)	1,838,503	1,838,503	8
9	Other(specify): See Attached Schedule	5,297	321,152	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,058,642	$ 5,879,310	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,151,920	13
14	Buildings, at Historical Cost		3,973,900	14
15	Leasehold Improvements, at Historical Cost	979,823	6,702,468	15
16	Equipment, at Historical Cost	1,120,156	1,969,500	16
17	Accumulated Depreciation (book methods)	(1,448,255)	(7,075,672)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		188,988	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	15,901	15,901	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 667,625	$ 6,927,005	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,726,267	$ 12,806,315	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,536,458	$ 1,536,687	26
27	Officer's Accounts Payable		112,358	27
28	Accounts Payable-Patient Deposits	(754)	(754)	28
29	Short-Term Notes Payable	2,868,197	2,868,197	29
30	Accrued Salaries Payable	301,239	301,239	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,361	14,361	31
32	Accrued Real Estate Taxes(Sch.IX-B)		406,082	32
33	Accrued Interest Payable		58,834	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	9,880	9,880	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	325,780	331,178	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,055,161	$ 5,638,062	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,789,228	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)**	$	$ 13,789,228	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,055,161	$ 19,427,290	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 671,106	$ (6,620,975)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,726,267	$ 12,806,315	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 637,759	1
2	Restatements (describe):		2
3	**Rounding Adjustment**	(4)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 637,755	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	33,351	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)**	$ 33,351	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)**	$ 671,106	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,652,025	1
2	Discounts and Allowances for all Levels	822,358	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,474,383	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,086,926	6
7	Oxygen	1,739	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,088,665	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	443,078	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	37,895	19
20	Radiology and X-Ray	12,515	20
21	Other Medical Services	82,555	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 576,043	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	43,217	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 43,217	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	16,017	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 16,017	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,198,325	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,326,313	31
32	Health Care	5,024,203	32
33	General Administration	4,691,126	33
	B. Capital Expense		
34	Ownership	2,757,995	34
	C. Ancillary Expense		
35	Special Cost Centers	1,202,729	35
36	Provider Participation Fee	162,608	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,164,974	40
41	**Income before Income Taxes (line 30 minus line 40)****	33,351	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 33,351	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.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,965	2,390	$ 128,137	$ 53.61	1
2	Assistant Director of Nursing	1,819	2,050	85,873	41.89	2
3	Registered Nurses	35,433	38,938	1,191,110	30.59	3
4	Licensed Practical Nurses	45,589	49,225	1,208,113	24.54	4
5	CNAs & Orderlies	91,307	100,518	1,091,959	10.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,133	7,133	74,615	10.46	8
9	Activity Director					9
10	Activity Assistants	7,633	8,245	82,268	9.98	10
11	Social Service Workers	5,150	5,502	146,668	26.66	11
12	Dietician	4,050	4,406	95,851	21.75	12
13	Food Service Supervisor					13
14	Head Cook	7,746	8,754	127,090	14.52	14
15	Cook Helpers/Assistants	17,014	19,426	188,683	9.71	15
16	Dishwashers					16
17	Maintenance Workers	14,059	15,085	240,611	15.95	17
18	Housekeepers	719	738	7,628	10.34	18
19	Laundry					19
20	Administrator	1,976	2,056	139,189	67.70	20
21	Assistant Administrator					21
22	Other Administrative	474	474	21,042	44.39	22
23	Office Manager	3,455	3,640	82,393	22.64	23
24	Clerical	5,873	7,806	188,419	24.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	11,421	12,431	183,883	14.79	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,833	4,259	64,187	15.07	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	18,822	20,462	381,356	18.64	33
34	TOTAL (lines 1 - 33)	285,471	313,538	$ 5,729,075 *	$ 18.27	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	309	$ 13,883	01-03	35
36	Medical Director	Monthly	43,500	09-03	36
37	Medical Records Consultant	Monthly	3,781	10-03	37
38	Nurse Consultant	482	12,050	10-03	38
39	Pharmacist Consultant	Monthly	6,826	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	31	2,388	11-03	44
45	Social Service Consultant	28	1,595	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	850	$ 84,023		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rick Walworth	Administrator	0.00%	$ 139,189
Kathleen Brander	Dir. Reg. Mgmt	0.00%	1,183
Marilyn Flaherty	VP of MC Reimb.	0.00%	19,859
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 160,231

B. Administrative - Other

Description	Amount
Administrative Fee-NuCare Services Corp	$ 775,885
Administrative Fee-CCS	63,896
TOTAL (agree to Schedule V, line 17, col. 3)	$ 839,781
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 22,527
See Attached	Legal	77,390
CDW	Computer Services	1,413
Emdeon	Computer Services	1,255
Giftrap	Computer Services	6,739
HDSI	Computer Services	7,050
MDI Achieve	Computer Services	3,495
PSD Solutions	Computer Services	12,876
Personnel Planners	Unemployment Tax Consult	2,002
Documentation Solutions	Healthcare Consulting	5,455
MTS Consulting	Tax Consulting	1,055
See Supplemetal Schedule		325
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 141,582

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 54,854
Unemployment Compensation Insurance	61,041
FICA Taxes	417,267
Employee Health Insurance	348,857
Employee Meals	1,719
Illinois Municipal Retirement Fund (IMRF)*	
401 K Matching	5,582
Pension	41,866
Dental Insurance	11,806
Other Employee Benefits	43,563
Chicago Head Tax	7,344
TOTAL (agree to Schedule V, line 22, col.8)	$ 993,899

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	20,607
Health Care Worker Background Check	
(Indicate # of checks performed 644)	8,131
Patient Background Checks	
IL Council on LTC	15,192
Dues & Subscriptions	2,198
Licenses & Inspections	1,185
Advertising & Promotions	26,436
See Supplemental Schedule	1,799
Less: Public Relations Expense	( )
Non-allowable advertising	(26,436)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 50,107

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	13,642
Allocated From NuCare	1,503
Allocated From CCS	219
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,364

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr **#** 0040022 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC $15,192**

(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. $ **34,270** Line **10-02**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **162,608**
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. $ **1,719** 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? **N/A** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100 % ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

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