

		FOR BHF USE					

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

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

I. IDPH License ID Number: 0040022

Facility Name: California Gardens N. & R.

Address: 2829 S. California Chicago 60608
Number City Zip Code

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 07/01/94

Type of Ownership:

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

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 01/01/11 to 12/31/11 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. & R.

0040022 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>297</u>	Skilled (SNF)	<u>297</u>	<u>108,405</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>297</u>	TOTALS	<u>297</u>	<u>108,405</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>6,864</u>	<u>6,864</u>	8
9	SNF/PED					9
10	ICF	<u>88,173</u>	<u>3,383</u>	<u>4,171</u>	<u>95,727</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>88,173</u>	<u>3,383</u>	<u>11,035</u>	<u>102,591</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.64%

D. How many bed-hold days during this year were paid by the Department? 2,359 (Do not include bed-hold days in Section B.)

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 297 and days of care provided 6,152

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

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

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

Facility Name & ID Number California Gardens N. & R. # 0040022 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	394,254	66,692	14,952	475,898		475,898		475,898			1
2	Food Purchase		505,312		505,312	(1,796)	503,516	(167)	503,350			2
3	Housekeeping	37,694	38,464	307,066	383,224		383,224		383,224			3
4	Laundry		48,498	154,283	202,781		202,781		202,781			4
5	Heat and Other Utilities			262,693	262,693		262,693	(6,698)	255,995			5
6	Maintenance	216,527	66,057	172,205	454,789		454,789	15,241	470,030			6
7	Other (specify):*											7
8	TOTAL General Services	648,475	725,023	911,199	2,284,697	(1,796)	2,282,901	8,376	2,291,277			8
	B. Health Care and Programs											
9	Medical Director			40,300	40,300		40,300		40,300			9
10	Nursing and Medical Records	4,358,330	819,055	22,003	5,199,388		5,199,388	(176,344)	5,023,044			10
10a	Therapy	56,554			56,554		56,554		56,554			10a
11	Activities	92,956	13,979	814	107,749		107,749		107,749			11
12	Social Services	197,659		2,183	199,842		199,842		199,842			12
13	CNA Training											13
14	Program Transportation			8,560	8,560		8,560		8,560			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,705,499	833,034	73,860	5,612,393		5,612,393	(176,344)	5,436,049			16
	C. General Administration											
17	Administrative	187,196		885,181	1,072,377		1,072,377	(856,537)	215,840			17
18	Directors Fees											18
19	Professional Services			116,097	116,097	(4,814)	111,283	31,556	142,839			19
20	Dues, Fees, Subscriptions & Promotions			113,234	113,234		113,234	(43,704)	69,530			20
21	Clerical & General Office Expenses	325,099	57,254	456,840	839,193		839,193	(34,370)	804,823			21
22	Employee Benefits & Payroll Taxes			1,003,334	1,003,334	1,796	1,005,130	(0)	1,005,130			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,647	13,647		13,647	(4,536)	9,111			24
25	Other Admin. Staff Transportation			826	826		826	1,240	2,066			25
26	Insurance-Prop.Liab.Malpractice			417,529	417,529		417,529	16,508	434,037			26
27	Other (specify):*							66,221	66,221			27
28	TOTAL General Administration	512,295	57,254	3,006,688	3,576,237	(3,019)	3,573,218	(823,622)	2,749,596			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,866,269	1,615,311	3,991,747	11,473,327	(4,814)	11,468,513	(991,590)	10,476,923			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			147,670	147,670		147,670	247,397	395,067			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			72,328	72,328		72,328	703,329	775,657			32
33	Real Estate Taxes					4,814	4,814	431,523	436,338			33
34	Rent-Facility & Grounds			2,848,471	2,848,471		2,848,471	(2,847,244)	1,227			34
35	Rent-Equipment & Vehicles			16,242	16,242		16,242	4,237	20,479			35
36	Other (specify):*							68,365	68,365			36
37	TOTAL Ownership			3,084,711	3,084,711	4,814	3,089,525	(1,392,393)	1,697,132			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	6,062	310,117	576,969	893,148		893,148		893,148			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			615,642	615,642		615,642		615,642			42
43	Other (specify):*	153,322		183,878	337,200		337,200	(337,200)	0			43
44	TOTAL Special Cost Centers	159,384	310,117	1,376,489	1,845,990		1,845,990	(337,200)	1,508,790			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,025,653	1,925,428	8,452,947	16,404,028		16,404,028	(2,721,183)	13,682,845			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(9,755)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(68,354)	30		9
10	Interest and Other Investment Income	(12)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(167)	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	(889)	21		18
19	Entertainment	(5,174)	24		19
20	Contributions	(19,375)	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	(234,262)	21		24
25	Fund Raising, Advertising and Promotional	(18,251)	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	(578,201)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (934,440)		\$	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)	(1,786,743)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,786,743)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,721,183)		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

ID#

0040022

Report Period Beginning:

01/01/11

Ending:

12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing Salary	\$ (7,440)	43	1
2	Guest Service Salary	(1,483)	21	2
3	Veterans Expenses	(159,709)	10	3
4	Patient Needs	(9,663)	10	4
5	Patient Clothing	(16,146)	10	5
6	Bank Charges	(22,457)	21	6
7	Jury Duty Income	(103)	10	7
8	Building Company Professional Fees	(11,420)	19	8
9	Building Company Amortization	(6,573)	36	9
10	Building Company Miscellaneous Liceses & Taxes	(5,315)	20	10
11	Building Company Bank Fees	(460)	21	11
12	Annual Report	(175)	20	12
13	Quest Management Fees	(183,878)	43	13
14	Records Copies	(985)	10	14
15	Capitalized R&M	(5,842)	06	15
16	Additional R&M	8,578	06	16
17	Non-Allowable Legal	(1,867)	19	17
18	Non-Reimbursable Salaries	(115,259)	43	18
19	Guest Related Salaries	(30,623)	43	19
20	COPE Dues	(7,380)	20	20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(578,201)		49

ID#0040022

Report Period Beginning:01/01/11

Ending:12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
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86				37
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93				44
94				45
95				46
96				47
97				48
98				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number California Gardens N. & R. # 0040022 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(167)											(167)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(9,755)		3,057									(6,698)	5
6	Maintenance	2,736		12,154		350							15,241	6
7	Other (specify):*													7
8	TOTAL General Services	(7,186)		15,211		350							8,376	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(186,607)				10,263							(176,344)	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	(186,607)				10,263							(176,344)	16
	C. General Administration													
17	Administrative			(798,675)	9,489	(67,351)							(856,537)	17
18	Directors Fees													18
19	Professional Services	(13,287)	11,420	33,423									31,556	19
20	Fees, Subscriptions & Promotions	(50,496)	5,315	1,435		42							(43,704)	20
21	Clerical & General Office Expenses	(259,551)	460	203,490		21,231							(34,370)	21
22	Employee Benefits & Payroll Taxes						(0)						(0)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(5,174)		366		272							(4,536)	24
25	Other Admin. Staff Transportation			852		387							1,240	25
26	Insurance-Prop.Liab.Malpractice		15,556	952									16,508	26
27	Other (specify):*			64,452	469	1,300							66,221	27
28	TOTAL General Administration	(328,508)	32,751	(493,705)	9,958	(44,118)	(0)						(823,622)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(522,301)	32,751	(478,493)	9,958	(33,505)	(0)						(991,590)	29

Summary B

12/31/11

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(68,354)	304,600	10,991		160							247,397	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(12)	699,868	3,290		183							703,329	32
33	Real Estate Taxes		421,261	10,262									431,523	33
34	Rent-Facility & Grounds		(2,847,785)	541									(2,847,244)	34
35	Rent-Equipment & Vehicles			4,237									4,237	35
36	Other (specify):*	(6,573)	74,938										68,365	36
37	TOTAL Ownership	(74,939)	(1,347,118)	29,321		343							(1,392,393)	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):*	(337,200)											(337,200)	43
44	TOTAL Special Cost Centers	(337,200)											(337,200)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(934,440)	(1,314,367)	(449,172)	9,958	(33,162)	(0)						(2,721,183)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 - Supplemental		See Page 6 - Supplemental		See Page 6 - Supplemental		

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 2,847,785	California Gardens Associates	100.00%	\$	(2,847,785)	1
2	V	32	Interest	226	California Gardens Associates	100.00%	700,094	699,868	2
3	V	19	Professional Fees		California Gardens Associates	100.00%	11,420	11,420	3
4	V	30	Depreciation		California Gardens Associates	100.00%	304,600	304,600	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%	421,261	421,261	6
7	V	26	Property & Liability Insurance		California Gardens Associates	100.00%	15,556	15,556	7
8	V	20	Misc Licenses & Taxes		California Gardens Associates	100.00%	5,315	5,315	8
9	V	36	MIP Expenses		California Gardens Associates	100.00%	68,365	68,365	9
10	V	21	Bank Fees		California Gardens Associates	100.00%	460	460	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 2,848,011			\$ 1,533,644	\$ * (1,314,367)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	NUCARE SERVICES CORP.	100.00%	\$ 3,057	\$	3,057 15
16	V	6	REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	12,154		12,154 16
17	V	17	ADMIN. - NON-OWNER		NUCARE SERVICES CORP.	100.00%	19,155		19,155 17
18	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	33,423		33,423 18
19	V	20	FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	1,435		1,435 19
20	V	21	CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	203,490		203,490 20
21	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	366		366 21
22	V	25	ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	852		852 22
23	V	26	INSURANCE		NUCARE SERVICES CORP.	100.00%	952		952 23
24	V	27	EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	64,452		64,452 24
25	V	30	DEPRECIATION		NUCARE SERVICES CORP.	100.00%	10,991		10,991 25
26	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	3,290		3,290 26
27	V	33	REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	10,262		10,262 27
28	V	34	PARKING LOT RENT		NUCARE SERVICES CORP.	100.00%	541		541 28
29	V	35	EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	4,237		4,237 29
30	V								30
31	V	17	MANAGEMENT FEES	817,830	NUCARE SERVICES CORP.	100.00%			(817,830) 31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 817,830			\$ 368,658	\$ *	(449,172) 39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. - G. JENICH		NUCARE SERVICES CORP.	100.00%	9,489	\$	9,489
16	V	17	ADMIN. - B. CARR		NUCARE SERVICES CORP.	100.00%			
17	V	17	ADMIN. - M. HARTMAN		NUCARE SERVICES CORP.	100.00%			
18	V								
19	V								
20	V	27	EMP. BEN. - G. JENICH		NUCARE SERVICES CORP.	100.00%	469		469
21	V	27	EMP. BEN. - B. CARR		NUCARE SERVICES CORP.	100.00%			
22	V	27	EMP. BEN. - M. HARTMAN		NUCARE SERVICES CORP.	100.00%			
23	V								
24	V								
25	V								
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$			9,958	\$ *	9,958

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MINOR EQUIPMENT	\$	CLINICAL CONSULTING SERVICES, LLC	100.00%	\$ 350	\$ 350	15
16	V	10	CLINICAL SALARIES		CLINICAL CONSULTING SERVICES, LLC	100.00%	10,263	10,263	16
17	V	19	PROFESSIONAL FEES		CLINICAL CONSULTING SERVICES, LLC	100.00%			17
18	V	20	DUES, LICENSE & INSPECTION		CLINICAL CONSULTING SERVICES, LLC	100.00%	42	42	18
19	V	21	OFFICE WAGES		CLINICAL CONSULTING SERVICES, LLC	100.00%	19,890	19,890	19
20	V	21	OFFICE EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	1,341	1,341	20
21	V	24	CONTINUING EDUCATION / SEMINAR		CLINICAL CONSULTING SERVICES, LLC	100.00%	272	272	21
22	V	25	AUTO EXPENSE		CLINICAL CONSULTING SERVICES, LLC	100.00%	387	387	22
23	V	27	PAYROLL TAXES		CLINICAL CONSULTING SERVICES, LLC	100.00%	103	103	23
24	V	27	OTHER EMPLOYEE BENEFITS		CLINICAL CONSULTING SERVICES, LLC	100.00%	1,197	1,197	24
25	V	30	DEPRECIATION		CLINICAL CONSULTING SERVICES, LLC	100.00%	160	160	25
26	V	32	INTEREST		CLINICAL CONSULTING SERVICES, LLC	100.00%	183	183	26
27	V								27
28	V	17	MANAGEMENT FEES	67,351	CLINICAL CONSULTING SERVICES, LLC	100.00%		(67,351)	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			\$ 67,351			\$ 34,189	\$ * (33,162)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Workers Compensation	\$ 80,560	Diamond Insurance	100.00%	\$ 80,560	\$ (0)	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			\$ 80,560			\$ 80,560	\$ * (0)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	BARRY & RANDY CARR	4.750%	CHEVY CHASE CORP. D/B/A BRONZEVILLE PARK NURSING & REH	CHICAGO	CALIFORNIA GARDENS ASSOC	LINCOLNWOOD	BUILDING CO.	1
2	BERNARD HOLLANDER FAMILY TRUST	4.750%	CLAREMONT EXTENDED HEALTHCARE, L.L.C.	BUFFALO GROVE	CLINICAL CONSULTING SERV	LINCOLNWOOD	CLINICAL CONSULTING	2
3	GARY HOKIN	25.000%	CLARIDGE IMPERIAL, LTD.	CHICAGO	QUEST SERVICES CORP.	LINCOLNWOOD	MARKETING	3
4	GERRY JENICH	5.000%	FOREST VILLA NURSING & REHABILITATION CENTER, L.L.C.	NILES	DBD REHABILITAION SERV.	CHICAGO	PSYCHIATRIC SERVICES	4
5	RAJCHENBACH FAMILY TRUST	4.750%	JACKSON CORP.	CHICAGO	JEM REHABILITATION SERV.	CHICAGO	PSYCHIATRIC SERVICES	5
6	ROBERT HARTMAN	55.750%	MONROE CORP.	CHICAGO	JLR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	6
7			THE RENAISSANCE AT 87TH STREET, INC.	CHICAGO	SEASONS HOSPICE	PARK RIDGE	HOSPICE	7
8			THE RENAISSANCE AT HILLSIDE, INC.	HILLSIDE	DIAMOND INSURANCE	HORTHBROOK	WORKERS COMP INS	8
9			THE RENAISSANCE AT MIDWAY, INC.	CHICAGO	7257 N. LINCOLN AVENUE, LLC	LINCOLNWOOD	BUILDING RENTAL	9
10			THE RENAISSANCE AT SOUTH SHORE, INC.	CHICAGO	NUCARE SERVICES	LINCOLNWOOD	BOOKEEPING / MANAGEME	10
11			RENAISSANCE EAST	MESA, ARIZONA	KFT SERVICES, LLC	LINCOLNWOOD	MANAGEMENT CO.	11
12			RENAISSANCE PARK SOUTH,LLC	CHICAGO	DRAKE LOUIS ENTERPRISE, LI	LINCOLNWOOD	MANAGEMENT CO.	12
13			RENAISSANCE VILLAGE AL	MESA, ARIZONA				13
14			RENAISSANCE VILLAGE IL	MESA, ARIZONA				14
15			RENAISSANCE WEST	MESA, ARIZONA				15
16			CLAREMONT - HANOVER PARK	HANOVER PARK				16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Gerry Jenich	Owner	Administrative	5%	See Attached	1.9	4.75%	Alloc Salary	\$ 9,489	17-7	1
2	David Hartman	Relative	Administrative	0%	See Attached	1	2.50%				2
3											3
4											4
5											5
6											6
7											7
8											8
9	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										9
10	IL Dept. of HFS.										10
11											11
12											12
13								TOTAL	\$ 9,489		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. & R. # 0040022 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

Facility Name & ID Number California Gardens N. & R. # 0040022 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	UTILITIES	AVAIL. CENSUS DAYS	1,283,340	16	\$ 36,192	\$	108,405	\$ 3,057	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	1,283,340	16	143,887		108,405	12,154	2
3	17	ADMIN. - NON-OWNER	AVAIL. CENSUS DAYS	1,283,340	16	226,766	211,441	108,405	19,155	3
4	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,283,340	16	395,673		108,405	33,423	4
5	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	1,283,340	16	16,986		108,405	1,435	5
6	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	1,283,340	16	2,408,992	(706,320)	108,405	203,490	6
7	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,283,340	16	4,332		108,405	366	7
8	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	1,283,340	16	10,088		108,405	852	8
9	26	INSURANCE	AVAIL. CENSUS DAYS	1,283,340	16	11,273		108,405	952	9
10	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	1,283,340	16	763,008		108,405	64,452	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,283,340	16	130,120		108,405	10,991	11
12	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,283,340	16	38,953		108,405	3,290	12
13	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,283,340	16	121,491		108,405	10,262	13
14	34	PARKING LOT RENT	AVAIL. CENSUS DAYS	1,283,340	16	6,400		108,405	541	14
15	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,283,340	16	50,154		108,405	4,237	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,364,315	\$		\$ 368,658	25

Facility Name & ID Number California Gardens N. & R. # 0040022 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	ADMIN. - G. JENICH	AVG. HOURS WORKED	10	5	50,000	50,000	2	9,489	1
2	17	ADMIN. - B. CARR	AVG. HOURS WORKED	10	4	40,000	40,000			2
3	17	ADMIN. - M. HARTMAN	AVG. HOURS WORKED	10	1	116,135	116,135			3
4										4
5										5
6	27	EMP. BEN. - G. JENICH	AVG. HOURS WORKED	10	5	2,471		2	469	6
7	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED	10	4	1,977				7
8	27	EMP. BEN. - M. HARTMAN	AVG. HOURS WORKED	10	1	5,737				8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 216,319	\$ 206,135		\$ 9,958	25

Facility Name & ID Number California Gardens N. & R. # 0040022 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	MINOR EQUIPMENT	AVAIL. CENSUS DAYS	1,283,340	17	\$ 4,147	\$	108,405	\$ 350	1
2	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,283,340	17	121,500	121,500	108,405	10,263	2
3	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,283,340	17			108,405		3
4	20	DUES, LICENSE & INSPECTION	AVAIL. CENSUS DAYS	1,283,340	17	500		108,405	42	4
5	21	OFFICE WAGES	AVAIL. CENSUS DAYS	1,283,340	17	235,467	235,467	108,405	19,890	5
6	21	OFFICE EXPENSE	AVAIL. CENSUS DAYS	1,283,340	17	15,872		108,405	1,341	6
7	24	CONTINUING EDUCATION / SE	AVAIL. CENSUS DAYS	1,283,340	17	3,225		108,405	272	7
8	25	AUTO EXPENSE	AVAIL. CENSUS DAYS	1,283,340	17	4,586		108,405	387	8
9	27	PAYROLL TAXES	AVAIL. CENSUS DAYS	1,283,340	17	1,222		108,405	103	9
10	27	OTHER EMPLOYEE BENEFITS	AVAIL. CENSUS DAYS	1,283,340	17	14,168		108,405	1,197	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,283,340	17	1,896		108,405	160	11
12	32	INTEREST	AVAIL. CENSUS DAYS	1,283,340	17	2,164		108,405	183	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 404,746	\$ 356,967		\$ 34,189	25

Facility Name & ID Number California Gardens N. & R. # 0040022 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Diamond Insurance
Street Address 40 Skokie Blvd., Suite 105
City / State / Zip Code Northbrook, IL 60062
Phone Number (847) 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	Dirrect Allocation			\$	\$		\$ 80,560	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					\$	\$		\$ 80,560	25

Facility Name & ID Number California Gardens N. & R. # 0040022 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

Facility Name & ID Number California Gardens N. & R. # 0040022 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number California Gardens N. & R. # 0040022 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

()

()

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

Facility Name & ID Number California Gardens N. & R. # 0040022 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

()

()

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

Facility Name & ID Number California Gardens N. & R. # 0040022 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	HUD Loan		X	Mortgage			\$	13,574,287			\$	700,094	1
2													2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	Bank of America		X	Working Capital				3,500,000				72,328	6
7													7
8	See Supplemental Schedule												8
9	TOTAL Facility Related						\$	17,074,287			\$	772,422	9
	B. Non-Facility Related*												
10	Interest Income		X									(12)	10
11	Interest Income- Building Co.		X									(226)	11
12	Allocated From NuCare		X									3,290	12
13	See Supplemental Schedule											183	13
14	TOTAL Non-Facility Related						\$				\$	3,235	14
15	TOTALS (line 9+line14)						\$	17,074,287			\$	775,657	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 68,365 Line # 36

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

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

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

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term												7
	Working Capital												
8							\$		\$			\$	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				\$		\$			\$	183
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related											183	20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	406,082	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.)				\$	413,844	2
3. Under or (over) accrual (line 2 minus line 1).				\$	7,762	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	423,761	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.				\$	4,814	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 \$ 13,292 For 2007 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.				\$	436,337	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2006	326,303	8	FOR BHF USE ONLY	
		2007	322,819	9		
		2008	326,058	10		
		2009	386,745	11		
		2010	403,582	12		
2011 Accrual = \$403,582 x 1.05 = \$423,761				13	FROM R. E. TAX STATEMENT FOR 2010	13
Allocated from NuCare: \$6,570				14	PLUS APPEAL COST FROM LINE 5	14
				15	LESS REFUND FROM LINE 6	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u>16-25-401-015-0000</u>	<u>Long Term Care Property</u>	\$ <u>403,581.54</u>	\$ <u>403,581.54</u>
2. <u>10-27-319-028-0000</u>	<u>Home Office Allocation</u>	\$ <u>81,875.48</u>	\$ <u>6,224.49</u>
3. <u>10-27-319-028-0000</u>	<u>Home Office Allocation</u>	\$ <u>81,875.48</u>	\$ <u>345.81</u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u>567,332.50</u>	\$ <u>410,151.84</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>California Gardens N. & R.</u>	COUNTY	<u>Cook</u>
---------------	---------------------------------------	--------	-------------

FACILITY IDPH LICENSE NUMBER 0040022

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

72,844

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

4

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

none

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

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	193,025	1987	\$ 300,000	1
2	Allocated From NuCare			12,840	2
3	TOTALS	193,025		\$ 312,840	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	297			1977	\$ 4,708,760	\$ 304,600		\$ 176,340	\$ (128,260)	\$ 2,710,774	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			4,290	18	
19	Various			1991	3,892		20	178	178	2,125	19	
20	Various			1993	24,138		20	1,207	1,207	13,276	20	
21	Various			1994	8,195		20	410	410	4,508	21	
22	Various			1995	17,230		20	862	862	14,355	22	
23	Various			1996	46,848		20	2,342	2,342	35,834	23	
24	Various			1997	70,702		20	3,482	3,482	51,863	24	
25	Various			1998	33,854		20	1,693	1,693	22,932	25	
26	Various			1999	103,092		20	5,155	5,155	64,340	26	
27	Various			2000	194,600		20	9,730	9,730	114,782	27	
28	Various			2001	75,921		20	3,796	3,796	40,063	28	
29	Various			2002	45,162		20	3,674	3,674	34,857	29	
30	Various			2003	55,404		20	2,576	2,576	38,745	30	
31	Various			2004	32,888		20	1,913	1,913	14,749	31	
32	Various			2005	23,434		20	2,414	2,414	15,566	32	
33	Various			2006	22,990		20	3,011	3,011	16,984	33	
34											34	
35											35	
36											36	

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

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		347,336			26,786	26,786	154,486	67
68	Related Party Allocations (Pages 12H & 12I)		244,670	8,095		6,970	(1,125)	45,155	68
69	Financial Statement Depreciation			147,670			(147,670)		69
70	TOTAL (lines 4 thru 69)		\$ 6,173,376	\$ 460,365		\$ 252,539	\$ (207,826)	\$ 3,427,224	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. & R.

0040022

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,173,376	\$ 460,365		\$ 252,539	\$ (207,826)	\$ 3,427,224	1
2	Elevator Repairs	2008	6,857		20	343	343	1,057	2
3	Landscape Irrigation System	2009	19,897		20	1,327	1,327	3,317	3
4	Install New Solid State Door Operator And Linkage Arms	2009	9,221		20	461	461	1,383	4
5	Laminated Cabinetry; 2 Elevators Finish In Laminate; 6 Pcs Hand	2009	15,980		20	1,598	1,598	4,395	5
6	1St Floor Corridor Signage	2009	4,146		20	415	415	968	6
7	Landscaping Design	2009	4,970		20	332	332	829	7
8	Concrete Main Entrance And Sidewalks	2009	5,450		20	364	364	909	8
9	Elevator Improvement	2009	2,900		20	145	145	302	9
10	Floor Work, Ceilings, Wall Work, Lighting	2009	212,688		20	10,634	10,634	29,245	10
11	Floor Work, Ceilings, Wall Work, Lighting	2009	145,278		20	7,264	7,264	18,765	11
12	Remodel Basement, 1St, 2Nd & 4Rd Flr. Corridor & Res. Rms., Di	2010	59,811		20	5,981	5,981	11,962	12
13	Elevator Door Jam, Removed Comp. Processessing Unit And Repa	2010	3,794		20	379	379	727	13
14	1 Pvi Water Heater,	2010	17,265		20	1,439	1,439	2,638	14
15	2000 Lft Chair Rail 5/8" X 2 1/2"	2010	4,390		20	878	878	1,098	15
16	Service And Replace 19 Smoke Detectors; 1 Valve Tamper & Insta	2010	3,769		20	377	377	471	16
17	2000 Linear Ft. Chair Rail oak Color For 2Nd Floor	2011	4,390		20	439	439	439	17
18	2005 Linera Ft Chair Rail 5/8" X 2 1/2	2011	4,341		20	398	398	398	18
19	2 Custom Wraparound Ss Grab Bars, 2 Shower Rods, 2 Grab Bar	2011	2,856		20	161	161	161	19
20	1 Commercial Gas Water Heater	2011	6,807		20	378	378	378	20
21	Shower Room, 4 Wrap Around Grab Bars, 4 Shower Rods, 4 24" (	2011	4,784		20	239	239	239	21
22	Grab Bars/Remodeling For 3Rd Floor Shower Room	2011	4,924		20	205	205	205	22
23	Fire Pump Repair	2011	3,069		20	153	153	153	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)		\$ 6,720,964	\$ 460,365		\$ 286,448	\$ (173,917)	\$ 3,507,261	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,720,964	\$ 460,365		\$ 286,448	\$ (173,917)	\$ 3,507,261	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
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16									16
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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)		\$ 6,720,964	\$ 460,365		\$ 286,448	\$ (173,917)	\$ 3,507,261	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,720,964	\$ 460,365		\$ 286,448	\$ (173,917)	\$ 3,507,261	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		\$ 6,720,964	\$ 460,365		\$ 286,448	\$ (173,917)	\$ 3,507,261	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 6,720,964	\$ 460,365		\$ 286,448	\$ (173,917)	\$ 3,507,261	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
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19									19
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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)		\$ 6,720,964	\$ 460,365		\$ 286,448	\$ (173,917)	\$ 3,507,261	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. & R.

0040022

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Various	2004	18,253		20	1,435	1,435	10,175	9
10	Various	2005	147,095		20	14,526	14,526	97,213	10
11	Interlocking Door Parts	2007	3,821		20	191	191	955	11
12	Clear Polish Wire Glass - 3 Rooms	2007	3,148		20	157	157	786	12
13	Clear Polish Wire Glass - 1 Room	2007	485		20	24	24	121	13
14	Cooling Tower	2007	36,990		20	1,850	1,850	9,249	14
15	2 Passenger Elevator	2007	6,721		20	336	336	1,680	15
16	Electrical Work	2007	17,065		20	853	853	4,266	16
17	Smoke Detectors and Standard Wire Bases	2007	3,509		20	175	175	876	17
18	Motor - Cooling Tower	2007	4,110		20	206	206	1,029	18
19	Tadiran IPx500 Telephone System	2008	21,467		20	2,147	2,147	8,588	19
20	Carpet; Armstrong Beckford	2008	7,103		20	355	355	1,420	20
21	Remote Annunciator Panel for Basement Generator	2008	3,852		20	193	193	772	21
22	Headend Installation and Home Run Wiring to Roof	2008	13,039		20	1,304	1,304	5,216	22
23	Change Heights of Outlets	2008	2,625		20	131	131	524	23
24	Video Monitoring System	2008	3,713		20	186	186	744	24
25	Outdoor Lighting	2008	8,415		20	421	421	1,684	25
26	CCTV to Monitor Floors	2008	3,469		20	173	173	692	26
27	Varieties of Burning Bushes	2008	8,175		20	409	409	1,636	27
28	Installation of Video Multiplexer Recorder	2008	2,710		20	136	136	544	28
29	Asphalt Paving Work	2008	4,350		20	218	218	872	29
30	Landscape Irrigation System	2008	18,000		20	900	900	3,600	30
31	New Elevator Door	2008	9,221		20	461	461	1,844	31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company Information Continued		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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 (12F & 12G lines 1 thru 33)		\$347,336	\$		\$26,786	\$26,786	\$154,486	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. & R.

0040022

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from NuCare 7257 N Lincoln Ave	2004	109,474	2,807	20	3,128	321	25,414	3
4	Allocated from Clinical Consulting Srvs 7257 N. Lincoln Ave	2004	6,082	156	20	174	18	1,412	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from NuCare	2003	989	43	20	50	7	402	9
10	Allocated from NuCare	2004	78,943	873	20	1,006	133	7,754	10
11	Allocated from NuCare	2005	1,191	52	20	60	8	408	11
12	Allocated from NuCare	2006	1,615	70	20	81	11	433	12
13	Allocated from NuCare	2008	1,702	74	20	85	11	277	13
14	Allocated from NuCare	2009	27,404	3,748	20	1,370	(2,378)	3,576	14
15	Allocated from NuCare	2010	4,211	183	20	211	28	317	15
16	Allocated from NuCare	2011	228	10	20	10		10	16
17									17
18	Allocated from NuCare 7257 N Lincoln Ave	2005	9,980	75	20	644	569	4,065	18
19	Allocated from NuCare 7257 N Lincoln Ave	2004	2,176		20	109	109	816	19
20									20
21	Allocated from Clinical Consulting Srvs 7257 N. Lincoln Ave	2005	554	4	20	36	32	226	21
22	Allocated from Clinical Consulting Srvs 7257 N. Lincoln Ave	2004	121		20	6	6	45	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		\$244,670	\$8,095		\$6,970	\$(1,125)	\$45,155	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$882,943	\$2,707	\$98,867	\$96,160	10	\$550,985	71
72	Current Year Purchases	95,652	317	9,431	9,114	10	9,431	72
73	Fully Depreciated Assets	380,559		171	171	10	380,559	73
74								74
75	TOTALS	\$1,359,154	\$3,024	\$108,469	\$105,445		\$940,975	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1996 FORD WAGON	1997	\$21,161	\$	\$	\$	5	\$21,160	76
77		Allocated From NuCare	2011	748	33	150	117	5	212	77
78										78
79										79
80	TOTALS			\$21,909	\$33	\$150	\$117		\$21,372	80

E. Summary of Care-Related Assets

	1	2	
		Reference	Amount
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$8,414,867
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$463,422
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$395,068
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(68,354)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,469,609

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Storage				686			5
6	Allocated From Nucare (Parking Lot)				541			6
7	TOTAL				\$1,227			7

**

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

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

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$20,479
- 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

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

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

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

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

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

12345678											
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	156,950	\$		\$ 156,950	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				161,577			161,577	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 03	hrs				246,911			246,911	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39 - 02	# of prescrpts				263,291			263,291	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify): See Supplemental			6,062			11,531	46,826		64,419	13
14	TOTAL			\$ 6,062		\$ 576,969	\$ 310,117		\$ 893,148	14	

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 5,443	\$ 407,187	1
2	Cash-Patient Deposits	36,937	36,937	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,627,082	5,627,082	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	20,000	20,000	5
6	Prepaid Insurance	167,199	167,199	6
7	Other Prepaid Expenses		60,593	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	885,621	1,360,419	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,742,282	\$ 7,679,417	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	1,026,226	6,748,871	15
16	Equipment, at Historical Cost	1,196,017	2,045,361	16
17	Accumulated Depreciation (book methods)	(1,595,925)	(7,527,942)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		182,415	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			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 626,318	\$ 6,574,525	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,368,600	\$ 14,253,942	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,606,053	\$ 1,606,052	26
27	Officer's Accounts Payable		57,362	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,500,000	3,500,000	29
30	Accrued Salaries Payable	526,327	526,327	30
31	Accrued Taxes Payable (excluding real estate taxes)	32,866	32,866	31
32	Accrued Real Estate Taxes(Sch.IX-B)		423,761	32
33	Accrued Interest Payable		57,917	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	9,880	9,880	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,710,895	1,710,895	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,386,021	\$ 7,925,060	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,574,287	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)	\$	\$ 13,574,287	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,386,021	\$ 21,499,347	46
47	TOTAL EQUITY(page 18, line 24)	\$ (17,421)	\$ (7,245,405)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,368,600	\$ 14,253,942	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 671,106	1
2	Restatements (describe):		2
3	Additional Bad Debts	(300,000)	3
4	Medicare Bad Debts	(15,620)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 355,486	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(372,907)	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)	\$ (372,907)	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)	\$ (17,421)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 14,503,389	1
2	Discounts and Allowances for all Levels	(609,347)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,894,042	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,304,610	6
7	Oxygen	11,602	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,316,212	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	618,830	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	53,037	19
20	Radiology and X-Ray	22,509	20
21	Other Medical Services	112,099	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 806,475	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	14,380	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 14,380	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,031,121	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,284,697	31
32	Health Care	5,612,393	32
33	General Administration	3,576,237	33
	B. Capital Expense		
34	Ownership	3,084,711	34
	C. Ancillary Expense		
35	Special Cost Centers	1,230,348	35
36	Provider Participation Fee	615,642	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,404,028	40
41	Income before Income Taxes (line 30 minus line 40)**	(372,907)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (372,907)	43

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

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

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

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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,714	1,831	\$ 100,627	\$ 54.96	1
2	Assistant Director of Nursing	3,958	1,904	82,445	43.30	2
3	Registered Nurses	35,743	39,668	1,148,799	28.96	3
4	Licensed Practical Nurses	54,061	59,103	1,504,837	25.46	4
5	CNAs & Orderlies	102,254	112,009	1,206,335	10.77	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,694	5,141	56,554	11.00	8
9	Activity Director					9
10	Activity Assistants	8,376	9,034	92,956	10.29	10
11	Social Service Workers	3,535	3,756	77,202	20.55	11
12	Dietician	3,811	4,924	102,265	20.77	12
13	Food Service Supervisor					13
14	Head Cook	5,838	6,698	103,331	15.43	14
15	Cook Helpers/Assistants	17,882	19,334	188,658	9.76	15
16	Dishwashers					16
17	Maintenance Workers	15,440	17,195	216,527	12.59	17
18	Housekeepers	3,417	3,647	37,694	10.34	18
19	Laundry					19
20	Administrator	1,941	2,166	134,261	61.99	20
21	Assistant Administrator					21
22	Other Administrative	860	860	52,935	61.55	22
23	Office Manager	1,856	2,096	55,059	26.27	23
24	Clerical	13,836	16,274	270,040	16.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	13,627	14,611	222,337	15.22	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,050	3,338	55,704	16.69	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	15,713	17,381	317,086	18.24	33
34	TOTAL (lines 1 - 33)	311,606	340,970	\$ 6,025,652 *	\$ 17.67	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	318	\$ 14,952	01-03	35
36	Medical Director	Monthly	40,300	09-03	36
37	Medical Records Consultant	Monthly	3,351	10-03	37
38	Nurse Consultant	478	11,950	10-03	38
39	Pharmacist Consultant	Monthly	6,702	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	14	814	11-03	44
45	Social Service Consultant	37	2,183	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	847	\$ 80,252		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	%	Amount	Description		Amount	Description		Amount	
Rick Walworth		Administrator	0	\$ 134,261	Workers' Compensation Insurance		\$ 80,560	IDPH License Fee		\$ 995	
Marilyn Flaherty		VP of MC Reimb.	0	14,522	Unemployment Compensation Insurance		68,466	Advertising: Employee Recruitment		27,933	
Farhat Sharif		Administrative	0	38,413	FICA Taxes		450,536	Health Care Worker Background Check			
					Employee Health Insurance		321,116	(Indicate # of checks performed 419)		4,779	
					Employee Meals		1,796	Patient Background Checks			
					Illinois Municipal Retirement Fund (IMRF)*			IL Council on LTC		28,726	
					City Taxes		7,360	Dues & Subscriptions		1,572	
					Pension		41,970	Licenses & Inspections		4,048	
					Dental Insurance		10,227	Advertising & Promotions		18,251	
					Other Employee Benefits		18,684	See Supplemental Schedule		1,477	
					401 K Matching		4,290	Less: Public Relations Expense		()	
					Vision Insurance		125	Non-allowable advertising		(18,251)	
								Yellow page advertising		()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 187,195	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,005,130	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 69,530
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description				Amount	Description		Line #	Amount	Description		Amount
Administrative Fee-NuCare Services Corp				\$ 817,830				\$	Out-of-State Travel		\$
Administrative Fee-CCS				67,351							
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 885,181							
C. Professional Services											
Vendor/Payee		Type		Amount							
Frost, Ruttenberg & Rothblatt		Accounting		\$ 23,255				\$			
See Attached		Legal		33,057							
Personnel Planners		UC Tax Consultant		1,644							
Documentation Solutions		Healthcare Consulting		2,436							
SAS Architects & Planners		Architectural Services		3,757							
LTD Consulting		Food Facility Design & Consult.		3,000							
CDW		Computer Services		1,580							
Emdeon		Computer Services		680					Seminar Expense		8,473
Giftrap		Computer Services		2,408					Allocated From NuCare		366
HDSI		Computer Services		4,037					Allocated From CCS		272
MDI Achieve		Computer Services		30,765							
See Supplemetal Schedule				9,478					Entertainment Expense		()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 116,097	TOTAL			\$	(agree to Sch. V, line 24, col. 8)		\$ 9,111

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

****See instructions.**

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.

ICLTC - \$28,978; IL Assoc. of HC Fac-\$7,128

(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 Yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$591

Line10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

(9) Are you presently operating under a sublease agreement?

YESXNO

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

YESNOX

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$615,642

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.

\$1,796

Has any meal income been offset against related costs?

N/A

Indicate the amount. \$

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

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 out of Schedule V?

Yes

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

Yes

Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT