

		FOR BHF USE				

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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 & Rehab C

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

County: Cook

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

HFS ID Number: 363961687001

Date of Initial License for Current Owners: 7/1/1994

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/07 to 12/31/07 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) _____
	(Type or Print Name) _____ (Date) _____
	(Title) _____
Paid Preparer	(Signed) _____ (Date) _____
	(Print Name and Title) <u>Kimberley A. Waite, C.P.A.</u>
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C

0040022 Report Period Beginning: 01/01/07 Ending: 12/31/07

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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>92,809</u>	<u>1,037</u>	<u>8,545</u>	<u>102,391</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>92,809</u>	<u>1,037</u>	<u>8,545</u>	<u>102,391</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.45%

D. How many bed-hold days during this year were paid by the Department? 2,692 (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 07/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES Date 07/01/94 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 6,858

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	374,400	79,781	12,659	466,840		466,840	466,840			1
2	Food Purchase		487,312		487,312	(1,730)	485,582	(181)	485,401		2
3	Housekeeping		60,586	417,960	478,546		478,546	478,546			3
4	Laundry		16,525	3,822	20,347		20,347	20,347			4
5	Heat and Other Utilities			322,250	322,250		322,250	3,174	325,424		5
6	Maintenance	173,720	37,074	106,161	316,955		316,955	19,732	336,687		6
7	Other (specify):*										7
8	TOTAL General Services	548,120	681,278	862,852	2,092,250	(1,730)	2,090,520	22,724	2,113,244		8
	B. Health Care and Programs										
9	Medical Director			45,000	45,000		45,000	45,000			9
10	Nursing and Medical Records	3,477,801	244,271	19,847	3,741,919		3,741,919	(30,825)	3,711,094		10
10a	Therapy	63,548		14,651	78,199		78,199	78,199			10a
11	Activities	101,854	9,744	1,636	113,234		113,234	113,234			11
12	Social Services	90,048		1,801	91,849		91,849	91,849			12
13	CNA Training										13
14	Program Transportation	94,627		2,123	96,750		96,750	96,750			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,827,878	254,015	85,058	4,166,951		4,166,951	(30,825)	4,136,126		16
	C. General Administration										
17	Administrative	175,702		987,987	1,163,689		1,163,689	(917,036)	246,653		17
18	Directors Fees										18
19	Professional Services			268,003	268,003	(13,962)	254,041	(27,730)	226,311		19
20	Dues, Fees, Subscriptions & Promotions			61,311	61,311		61,311	(37,624)	23,687		20
21	Clerical & General Office Expenses	329,090	50,979	269,102	649,171		649,171	2,062	651,233		21
22	Employee Benefits & Payroll Taxes			822,779	822,779	1,730	824,509	824,509			22
23	Inservice Training & Education										23
24	Travel and Seminar			5,801	5,801		5,801	364	6,165		24
25	Other Admin. Staff Transportation			572	572		572	1,551	2,123		25
26	Insurance-Prop.Liab.Malpractice			248,300	248,300		248,300	18,090	266,390		26
27	Other (specify):*							42,133	42,133		27
28	TOTAL General Administration	504,792	50,979	2,663,855	3,219,626	(12,232)	3,207,394	(918,191)	2,289,204		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,880,790	986,272	3,611,765	9,478,827	(13,962)	9,464,865	(926,292)	8,538,573		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab C #0040022 Report Period Beginning: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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	
	D. Ownership											
30	Depreciation			57,573	57,573		57,573	270,113	327,686			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			197,265	197,265		197,265	714,311	911,576			32
33	Real Estate Taxes					13,962	13,962	293,646	307,608			33
34	Rent-Facility & Grounds			2,376,152	2,376,152		2,376,152	(2,375,503)	649			34
35	Rent-Equipment & Vehicles			5,912	5,912		5,912	4,911	10,823			35
36	Other (specify):*							72,262	72,262			36
37	TOTAL Ownership			2,636,902	2,636,902	13,962	2,650,864	(1,020,260)	1,630,604			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		352,799	718,319	1,071,118		1,071,118		1,071,118			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			162,608	162,608		162,608		162,608			42
43	Other (specify):*	52,964			52,964		52,964	(52,964)				43
44	TOTAL Special Cost Centers	52,964	352,799	880,927	1,286,690		1,286,690	(52,964)	1,233,726			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,933,754	1,339,071	7,129,594	13,402,419		13,402,419	(1,999,516)	11,402,903			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning: 01/01/07

Ending: 12/31/07

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(34,893)	30		9
10	Interest and Other Investment Income	(32,316)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(49)	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	(1,076)	21		18
19	Entertainment	(2,098)	24		19
20	Contributions	(11,955)	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	(162,118)	21		24
25	Fund Raising, Advertising and Promotional	(23,194)	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	(213,258)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (480,957)		\$	30

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

		1	2	
		Amount	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)	(1,518,558)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,518,558)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,999,516)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops	20				41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

SEE ACCOUNTANTS' COMPILATION REPORT

HW 0040022
 Report Period Beginning: 01/01/07
 Ending: 12/31/07

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 Veterans Expenses	\$ (27,039)	10	1
2 Patients Needs	(3,700)	19	2
3 Copying Income	(1,089)	23	3
4 Food Rebate	(132)	02	4
5 Telephone Income	(83)	23	5
6 Duty Duty Income	(86)	10	6
7 Bank Charges	(16,843)	23	7
8 Prior Year Legal Expense	(26,837)	19	8
9 Annual Report	(175)	20	9
10 Marketing Salaries	(23,739)	43	10
11 Clinical Nurse Evaluator Salaries	(50,225)	43	11
12 CPPE Dues	(3,914)	20	12
13 Professional Fees- Building Co.	(9,060)	19	13
14 Amortization- Building Co.	(6,573)	36	14
15 Licenses- Taxes- Building Co.	(6,290)	20	15
16 Appraisal Fee- Building Co.	(3,250)	19	16
17 Non-Allowable Legal Fees	(16,438)	19	17
18 Non-Allowable Office Expense	(36,788)	23	18
19			19
20			20
21			21
22			22
23			23
24			24
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97			97
98			98
99			99
100			100
101 Total	(213,258)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(181)											(181)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			3,174									3,174	5
6	Maintenance		14,304	5,428									19,732	6
7	Other (specify):*													7
8	TOTAL General Services	(181)	14,304	8,601									22,724	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(30,825)											(30,825)	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	(30,825)											(30,825)	16
	C. General Administration													
17	Administrative			(917,036)									(917,036)	17
18	Directors Fees													18
19	Professional Services	(55,585)	12,310	15,545									(27,730)	19
20	Fees, Subscriptions & Promotions	(45,526)	6,290	1,612									(37,624)	20
21	Clerical & General Office Expenses	(219,996)		222,058									2,062	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(2,098)		2,462									364	24
25	Other Admin. Staff Transportation			1,551									1,551	25
26	Insurance-Prop.Liab.Malpractice		16,230	1,860									18,090	26
27	Other (specify):*			42,133									42,133	27
28	TOTAL General Administration	(323,205)	34,830	(629,816)									(918,191)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(354,211)	49,134	(621,214)									(926,292)	29

STATE OF ILLINOIS

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning:

01/01/07

Ending:

Summary B

12/31/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(34,893)	289,693	15,313									270,113	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(32,316)	736,121	10,506									714,311	32
33	Real Estate Taxes		286,873	6,773									293,646	33
34	Rent-Facility & Grounds		(2,376,152)	649									(2,375,503)	34
35	Rent-Equipment & Vehicles			4,911									4,911	35
36	Other (specify):*	(6,573)	78,835										72,262	36
37	TOTAL Ownership	(73,782)	(984,630)	38,152									(1,020,260)	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):*	(52,964)											(52,964)	43
44	TOTAL Special Cost Centers	(52,964)											(52,964)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(480,957)	(935,496)	(583,062)									(1,999,516)	45

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning:

01/01/07

Ending:

12/31/07

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		California Associates		Building Co.
				See Attached		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 2,376,152	California Associates	100.00%	\$	\$ (2,376,152)	1
2	V	32 Interest	3,871	California Associates	100.00%	739,992	736,121	2
3	V	19 Professional Fees		California Associates	100.00%	9,060	9,060	3
4	V	30 Depreciation		California Associates	100.00%	289,693	289,693	4
5	V	36 Amortization		California Associates	100.00%	6,573	6,573	5
6	V	33 Real Estate Tax		California Associates	100.00%	286,873	286,873	6
7	V	26 Property & Liability Insurance		California Associates	100.00%	16,230	16,230	7
8	V	20 Misc. Licenses & Taxes		California Associates	100.00%	6,290	6,290	8
9	V	36 MIP Expense		California Associates	100.00%	72,262	72,262	9
10	V	06 Repairs & Maintenance		California Associates	100.00%	14,304	14,304	10
11	V	19 Appraisal Fee		California Associates	100.00%	3,250	3,250	11
12	V							12
13	V							13
14	Total		\$ 2,380,023			\$ 1,444,527	\$ * (935,496)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C# 0040022Report Period Beginning: 01/01/07Ending: 12/31/07

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%	\$ 3,174	\$ 3,174	15
16	V	6 REPAIRS AND MAINT.				5,428	5,428	16
17	V	17 ADMIN. - NON-OWNER				39,116	39,116	17
18	V	19 PROFESSIONAL FEES				15,545	15,545	18
19	V	20 FEES SUBSCRIPTIONS				1,612	1,612	19
20	V	21 CLERICAL & GENERAL				222,058	222,058	20
21	V	24 SEMINARS AND EDUCATION				2,462	2,462	21
22	V	25 ADMIN. STAFF TRAVEL				1,551	1,551	22
23	V	26 INSURANCE				1,860	1,860	23
24	V	27 EMPLOYEE BEN. GEN. ADMIN.				29,844	29,844	24
25	V	30 DEPRECIATION				15,313	15,313	25
26	V	32 INTEREST EXPENSE				10,506	10,506	26
27	V	33 REAL ESTATE TAX				6,773	6,773	27
28	V	34 PARKING LOT RENT				649	649	28
29	V	35 EQUIPMENT RENTAL				4,911	4,911	29
30	V	17 ADMIN. - R. HARTMAN				20,320	20,320	30
31	V	17 ADMIN. - B. CARR				11,515	11,515	31
32	V	17 ADMIN. - D. HARTMAN						32
33	V	27 EMP. BEN. - R. HARTMAN				9,886	9,886	33
34	V	27 EMP. BEN. - B. CARR				2,403	2,403	34
35	V	27 EMP. BEN. - D. HARTMAN						35
36	V							36
37	V	17 MANAGEMENT FEES	987,987				(987,987)	37
38	V							38
39	Total		\$ 987,987			\$ 404,925	\$ * (583,062)	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 Workmans Compensation	\$ 75,489	Diamond Insurance	100.00%	\$ 75,489	\$	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		\$ 75,489			\$ 75,489	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

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

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.

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

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning: 01/01/07

Ending: 12/31/07

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

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	Robert Hartman	Owner	Administrative	31.85%	See Attached	1.13	2.26%	Alloc. Nucare	\$ 20,320	17-7	1
2	Barry Carr	Owner	Administrative	N/A	See Attached	5.64	11.28%	Alloc. Nucare	11,515	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 31,835		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS 960,286	12	\$ 28,115	\$	108,405	\$ 3,174	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS 960,286	12	48,079		108,405	5,428	2
3	17	ADMIN. - NON-OWNER	AVAIL. CENSUS DAYS 960,286	12	346,499	346,499	108,405	39,116	3
4	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS 960,286	12	137,702		108,405	15,545	4
5	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS 960,286	12	14,277		108,405	1,612	5
6	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS 960,286	12	1,967,057	1,688,717	108,405	222,058	6
7	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS 960,286	12	21,810		108,405	2,462	7
8	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS 960,286	12	13,739		108,405	1,551	8
9	26	INSURANCE	AVAIL. CENSUS DAYS 960,286	12	16,477		108,405	1,860	9
10	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS 960,286	12	264,372		108,405	29,844	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS 960,286	12	135,649		108,405	15,313	11
12	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS 960,286	12	93,063		108,405	10,506	12
13	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS 960,286	12	60,000		108,405	6,773	13
14	34	PARKING LOT RENT	AVAIL. CENSUS DAYS 960,286	12	5,749		108,405	649	14
15	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS 960,286	12	43,501		108,405	4,911	15
16	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED 10	12	180,000	180,000	108,405	20,320	16
17	17	ADMIN. - B. CARR	AVG. HOURS WORKED 50	12	102,000	102,000	108,405	11,515	17
18	17	ADMIN. - D. HARTMAN	AVG. HOURS WORKED 40	2	80,000	80,000	108,405		18
19	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED 10	12	87,577		108,405	9,886	19
20	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED 50	12	21,286		108,405	2,403	20
21	27	EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED 40	2	16,421		108,405		21
22									22
23									23
24									24
25	TOTALS				\$ 3,683,372	\$ 2,397,215		\$ 404,925	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Diamond Insurance
 Street Address 40 Skokie Blvd, Suite 105
 City / State / Zip Code Northbrook, IL 60062
 Phone Number (847) 559-1002
 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	Workmans Compensation	Direct Allocation		\$	\$		\$ 75,489	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				\$	\$		\$ 75,489	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C

0040022 Report Period Beginning: 01/01/07 Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning:

01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	HUD Loan		X	Mortgage			\$	\$ 14,371,921			\$ 739,992	1					
2												2					
3												3					
4												4					
5	See Supplemental Schedule											5					
Working Capital																	
6	Shareholder Loan		X	Working Capital				3,800,000			197,265	6					
7	Alloc from Nuicare Services		X								10,506	7					
8	See Supplemental Schedule											8					
9	TOTAL Facility Related						\$	\$ 18,171,921			\$ 947,763	9					
B. Non-Facility Related*																	
10	Interest Income										(32,316)	10					
11	Interest Income(Bldg Co.)										(3,871)	11					
12												12					
13	See Supplemental Schedule											13					
14	TOTAL Non-Facility Related						\$	\$			\$ (36,187)	14					
15	TOTALS (line 9+line14)						\$	\$ 18,171,921			\$ 911,576	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 72,262 Line # 36

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

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

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/07 Ending: 12/31/07

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							\$	\$			\$	15							
16												16							
17												17							
18												18							
19												19							
20	TOTAL Non-Facility Related											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.)

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME California Gardens N & Rehab C 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 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? YES NO

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

C. Tax Bills

Attach a copy of the 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.

Facility Name & ID Number California Gardens N & Rehab C# 0040022 Report Period Beginning:01/01/07 Ending:12/31/07**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 72,844 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4C. 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).

NoneF. 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	<u>Facility</u>	<u>193,025</u>	<u>1987</u>	<u>\$ 300,000</u>	<u>1</u>
2	<u>7257 N. Lincoln Allocation</u>		<u>2004</u>	<u>18,062</u>	<u>2</u>
3	TOTALS	193,025		\$ 318,062	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	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	1,838	1,838	13,868	15
16	Various		1988		2,787		20	139	139	2,659	16
17	Various		1989		3,024		20	151	151	1,058	17
18	Various		1990		8,652		20	433	433	3,029	18
19	Various		1991		3,892		20	195	195	1,363	19
20	Various		1993		24,138		20	1,207	1,207	8,448	20
21	Various		1994		8,195		20	410	410	2,869	21
22	Various		1995		17,230		20	863	863	10,910	22
23	Various		1996		46,848		20	2,342	2,342	26,464	23
24	Various		1997		70,702		20	3,565	3,565	37,936	24
25	Various		1998		33,854		20	1,695	1,695	16,162	25
26	Various		1999		103,092		20	5,155	5,155	43,722	26
27	Various		2000		194,600		20	9,736	9,736	75,864	27
28	Various		2001		75,921		20	3,800	3,800	24,880	28
29	Various		2002		45,162		20	3,675	3,675	20,162	29
30	Various		2003		55,404		20	4,869	4,869	22,910	30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		4,874,108	289,693		192,301	(97,392)	2,048,958	67
68		217,799	7,606		7,439	(167)	28,115	68
69			57,573			(57,573)		69
70		\$ 5,885,205	\$ 354,872		\$ 239,813	\$ (115,059)	\$ 2,398,917	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,885,205	\$ 354,872		\$ 239,813	\$ (115,059)	\$ 2,398,917	1
2	Installed Cctv Monitor	2004	1,873		20	48	48	190	2
3	Eletronic Work For Reception Desk	2004	1,379		20	35	35	137	3
4	Installed Cctv - Outside Back Parking Lot	2004	1,380		20	138	138	540	4
5	Installed Alarm Control At Reception	2004	1,728		20	173	173	662	5
6	Alarm System Service	2004	998		20	100	100	391	6
7	Installed Monitoring System	2004	1,281		20	128	128	502	7
8	Telephone Wiring	2004	820		20	82	82	321	8
9	10 Schlage Standard Duty Door Knobs	2004	879		20	88	88	330	9
10	Installed Alarm Reset Control Box	2004	896		20	90	90	343	10
11	Installed Telephone Lines And Outlets	2004	825		20	83	83	303	11
12	Installed 2 Pull Stations And Service	2004	759		20	76	76	304	12
13	Installed Digital Keypad	2004	597		20	60	60	239	13
14	Installed Video Processor And Service	2004	942		20	94	94	377	14
15	Installed Alarm Reset Key Switch	2004	782		20	78	78	267	15
16	Roof Repair & Reseal Deposit	2004	1,500		20	38	38	141	16
17	Additional Roof Repair Deposit	2004	1,000		20	26	26	90	17
18	Additional Roof Repair And Remaining Balance Due	2004	7,600		20	195	195	666	18
19	Overtime Service Call 3 Hrs	2004	1,090		20	54	54	182	19
20	Telephone Repair Service	2004	825		20	41	41	141	20
21	Exterior Lighting Repairs	2004	787		20	39	39	125	21
22	Cctv Repairs	2004	760		20	38	38	152	22
23	Generator Repairs	2004	703		20	35	35	123	23
24	Glass Repairs	2004	815		20	41	41	143	24
25	Repair Wiring For Smoke Detectors	2004	552		20	28	28	85	25
26	Wireless Annunciator And Motion Detector	2005	1,181		20	169	169	408	26
27	Cctv For Monitoring System	2005	1,137		20	162	162	393	27
28	Smoke Detector	2005	956		20	137	137	341	28
29	New Packing And Valve	2005	6,081		20	608	608	1,368	29
30	New Packing And Valve (Check Voided In 2007)	2005	(6,081)		20	(608)	(608)	(1,368)	30
31	Ceiling Tile	2005	2,040		20	102	102	247	31
32	Security Monitoring System	2005	6,215		20	888	888	2,294	32
33	Break Room And Barber Shop	2005	3,200		20	320	320	720	33
34	TOTAL (lines 1 thru 33)		\$ 5,930,705	\$ 354,872		\$ 243,399	\$ (111,473)	\$ 2,410,074	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,930,705	\$ 354,872		\$ 243,399	\$ (111,473)	\$ 2,410,074	1
2	Wiring	2005	4,026		20	403	403	839	2
3	Elevator Repair	2005	882		20	44	44	118	3
4	Nurse Call System	2005	1,280		20	64	64	192	4
5	Drywall	2005	515		20	26	26	75	5
6	Vinyl Tile And Adhesive	2005	677		20	34	34	102	6
7	Service On Monitor System	2005	1,325		20	66	66	182	7
8	Telephone Cables	2006	1,188		20	119	119	238	8
9	24 Vac Ccd Camera And Monitor Install	2006	1,345		20	192	192	304	9
10	Fire Alarm Boards	2006	2,183		20	312	312	494	10
11	Smoke Detectors And Alarms	2006	2,772		20	396	396	627	11
12	Musak Music, Paging System	2006	963		20	138	138	275	12
13	New Elevator Door	2006	8,521		20	852	852	994	13
14	Windows	2006	6,018		20	1,204	1,204	1,404	14
15	Interlocking Door Parts	2007	3,821		20	318	318	318	15
16	Clear Polish Wire Glass - 3 Rooms	2007	3,148		20	184	184	184	16
17	Clear Polish Wire Glass - 1 Room	2007	485		20	28	28	28	17
18	Cooling Tower	2007	36,990		20	1,850	1,850	1,850	18
19	2 Passenger Elevator	2007	6,721		20	280	280	280	19
20	Elevator Located At 2829 S. California	2007	2,350		20	235	235	235	20
21	Smoke Detectors And Standard Wire Bases	2007	3,509		20	234	234	234	21
22	Motor - Cooling Tower	2007	4,110		20	103	103	103	22
23	Electrical Work	2007	17,065		20	284	284	284	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)		\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward	\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434	1	
2								2	
3								3	
4								4	
5								5	
6								6	
7								7	
8								8	
9								9	
10								10	
11								11	
12								12	
13								13	
14								14	
15								15	
16								16	
17								17	
18								18	
19								19	
20								20	
21								21	
22								22	
23								23	
24								24	
25								25	
26								26	
27								27	
28								28	
29								29	
30								30	
31								31	
32								32	
33								33	
34	TOTAL (lines 1 thru 33)	\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434	34	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12L, Carried Forward	\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434		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)	\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12M, Carried Forward		\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434	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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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)		\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12N, Carried Forward		\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12O, Carried Forward		\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434	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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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)		\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434	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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19									19
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,040,599	\$ 354,872		\$ 250,765	\$ (104,107)	\$ 2,419,434	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	297		1998	1977	\$ 4,708,760	\$ 289,693		\$ 176,340	\$ (113,353)	\$ 2,005,414	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		2 V-SHAPED SIGNS		2004	13,000		20	1,300	1,300	4,008	9
10		REPLACED ELEVATOR DOOR TRACKS		2004	5,253		20	135	135	427	10
11		Light fixtures		2005	10,837		20	1,084	1,084	3,161	11
12		New data cables		2005	1,567		20	157	157	431	12
13		Concrete installation		2005	16,568		20	1,657	1,657	4,556	13
14		Elevator car station - fire service upgrade		2005	60,648		20	6,065	6,065	16,173	14
15		Elevator recall face		2005	10,819		20	1,082	1,082	2,975	15
16		Nursing station and medical room for 2 floors		2005	24,800		20	2,480	2,480	6,613	16
17		CCTV for monitoring system		2005	1,592		20	227	227	682	17
18		CCTV for monitoring system		2005	983		20	140	140	421	18
19		A/C Motor Lincoln		2005	1,728		20	247	247	638	19
20		Polish wire glass for dining room		2005	620		20	62	62	155	20
21		Carpeting installation		2005	850		20	121	121	293	21
22		Front reception window granite tops and employee lunch room		2005	8,000		20	800	800	1,933	22
23		Elevator passenger car wiring		2005	8,083		20	404	404	1,078	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
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54								54				
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56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	4,874,108	\$	289,693	\$	192,301	\$	(97,392)	\$	2,048,958	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Alloc from 7257 N. Lincoln Ave		2004	2004	\$ 167,831	\$ 4,168	35	\$ 4,723	\$ 555	\$ 19,708	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated from Nucare Services Corp.			2003	1,322	48	20	66	18	273	9
10	Allocated from Nucare Services Corp.			2004	26,846	980	20	1,344	364	4,985	10
11	Allocated from Nucare Services Corp.			2005	1,592	58	20	80	22	227	11
12	Allocated from Nucare Services Corp.			2006	2,158	79	20	108	29	147	12
13											13
14	Allocated from 7257 N. Lincoln Ave, LLC			2005	14,819	1,901	20	956	(945)	2,210	14
15	Allocated from 7257 N. Lincoln Ave, LLC			2004	3,231	372	20	162	(210)	565	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
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49								49				
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51								51				
52								52				
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54								54				
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56								56				
57								57				
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60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	217,799	\$	7,606	\$	7,439	\$	(167)	\$	28,115	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab C # 0040022 Report Period Beginning: 01/01/07 Ending: 12/31/07

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 691,466	\$ 7,079	\$ 74,029	\$ 66,950	10	\$ 455,393	71
72	Current Year Purchases	71,604	627	2,802	2,175	10	2,802	72
73	Fully Depreciated Assets	121,716		89	89	10	121,716	73
74								74
75	TOTALS	\$ 884,786	\$ 7,706	\$ 76,920	\$ 69,214		\$ 579,911	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1996 FORD WAGON	1997	\$ 21,161	\$	\$	\$	5	\$ 21,160	76
77										77
78										78
79										79
80	TOTALS			\$ 21,161	\$	\$	\$		\$ 21,160	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 7,264,608	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 362,578	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 327,685	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ (34,893)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 3,020,505	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	<u>Allocated from Nucare Services Corp.</u>				<u>649</u>			6
7	TOTAL				\$ 649			7

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.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

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: \$ 7,175 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocated from Nucare Services Corp.</u>		\$	\$ <u>3,648</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 3,648	21

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	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	\$		\$ 248,666	\$		\$ 248,666	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			164,903			164,903	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			274,408			274,408	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 prescripts				225,254		225,254	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>See Supplemental</u>					30,342	127,545		157,887	13
14	TOTAL			\$		\$ 718,319	\$ 352,799		\$ 1,071,118	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C# 0040022Report Period Beginning: 01/01/07

Ending:

12/31/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 400	\$ 273,592	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	4,737,661	4,853,507	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	81,442	81,442	6
7	Other Prepaid Expenses	18,504	83,918	7
8	Accounts Receivable (owners or related parties)	1,102,731	1,102,731	8
9	Other(specify): <u>See Attached Schedule</u>	9,049	844,560	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,949,787	\$ 7,239,750	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	786,848	6,069,800	15
16	Equipment, at Historical Cost	784,011	1,502,980	16
17	Accumulated Depreciation (book methods)	(1,093,896)	(5,820,728)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		208,707	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	76,913	76,913	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 553,876	\$ 7,163,492	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,503,663	\$ 14,403,242	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 907,174	\$ 907,173	26
27	Officer's Accounts Payable		112,358	27
28	Accounts Payable-Patient Deposits	(1,127)	(1,127)	28
29	Short-Term Notes Payable	3,800,000	3,800,000	29
30	Accrued Salaries Payable	388,448	388,448	30
31	Accrued Taxes Payable (excluding real estate taxes)	25,729	25,729	31
32	Accrued Real Estate Taxes(Sch.IX-B)		342,618	32
33	Accrued Interest Payable		61,320	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	10,346	10,346	35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	7,051	7,804	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,137,621	\$ 5,654,669	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		14,371,921	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 14,371,921	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,137,621	\$ 20,026,590	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,366,042	\$ (5,623,348)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,503,663	\$ 14,403,242	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 841,314	1
2	Restatements (describe):		2
3	Additional Allowance	(125,000)	3
4	Medicare Bad Debts Receivable	(18,816)	4
5	S&E Medical Accrual	(64,495)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 633,003	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	733,039	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)	\$ 733,039	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)	\$ 1,366,042	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C# 0040022Report Period Beginning: 01/01/07Ending: 12/31/07**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	\$ 12,380,624	1
2	Discounts and Allowances for all Levels	(217,337)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,163,287	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,445,236	6
7	Oxygen	3,823	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,449,059	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	369,527	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,772	19
20	Radiology and X-Ray	4,753	20
21	Other Medical Services	59,332	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 455,384	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	32,299	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 32,299	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	35,429	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 35,429	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,135,458	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,092,250	31
32	Health Care	4,166,951	32
33	General Administration	3,219,626	33
B. Capital Expense			
34	Ownership	2,636,902	34
C. Ancillary Expense			
35	Special Cost Centers	1,124,082	35
36	Provider Participation Fee	162,608	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,402,419	40
41	Income before Income Taxes (line 30 minus line 40)**	733,039	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 733,039	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.

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning: 01/01/07

Ending:

12/31/07

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	1,887	2,358	\$ 119,922	\$ 50.86	1
2	Assistant Director of Nursing	1,861	2,103	83,485	39.70	2
3	Registered Nurses	29,552	32,834	900,564	27.43	3
4	Licensed Practical Nurses	39,617	43,043	1,029,391	23.92	4
5	CNAs & Orderlies	92,160	101,843	1,069,670	10.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,631	6,231	63,548	10.20	8
9	Activity Director	1,851	2,086	31,048	14.88	9
10	Activity Assistants	7,784	8,190	70,806	8.65	10
11	Social Service Workers	3,994	4,314	90,048	20.87	11
12	Dietician	3,980	4,438	93,011	20.96	12
13	Food Service Supervisor					13
14	Head Cook	7,608	8,721	114,308	13.11	14
15	Cook Helpers/Assistants	17,841	19,700	167,081	8.48	15
16	Dishwashers					16
17	Maintenance Workers	10,402	11,676	173,720	14.88	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,961	2,126	88,048	41.41	20
21	Assistant Administrator	759	789	12,032	15.25	21
22	Other Administrative	1,008	1,008	75,622	75.02	22
23	Office Manager					23
24	Clerical	16,621	18,541	329,090	17.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	15,601	16,966	214,714	12.66	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,558	3,969	60,055	15.13	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	9,635	10,620	147,591	13.90	33
34	TOTAL (lines 1 - 33)	273,311	301,556	\$ 4,933,754 *	\$ 16.36	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	301	\$ 12,659	01-03	35
36	Medical Director	Monthly	45,000	09-03	36
37	Medical Records Consultant	Monthly	4,224	10-03	37
38	Nurse Consultant	372	9,695	10-03	38
39	Pharmacist Consultant	Monthly	5,928	10-03	39
40	Physical Therapy Consultant	64	2,874	10a-03	40
41	Occupational Therapy Consultant	10	430	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	11	10a-03	43
44	Activity Consultant	30	1,636	11-03	44
45	Social Service Consultant	33	1,801	12-03	45
46	Other(specify)				46
47	<u>DD Therapy Consultant</u>	103	6,328	10a-03	47
48	<u>Therapy Consultant</u>	30	5,008	10a-03	48
49	TOTAL (lines 35 - 48)	944	\$ 95,594		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

Facility Name & ID Number California Gardens N & Rehab C

0040022

Report Period Beginning: 01/01/07

Ending: 12/31/07

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Rick Walworth	Administrator	0	\$ 126,836	Workers' Compensation Insurance	\$ 75,489	IDPH License Fee	\$ 995	
Kathleen Brander	Dir of Regulatory Mgmt	0	15,658	Unemployment Compensation Insurance	66,963	Advertising: Employee Recruitment	1,515	
Marilyn Flaherty	VP Medicare Reimb	0	20,730	FICA Taxes	376,482	Health Care Worker Background Check		
Jennifer Bebinger	Alzheimers Unit Dir	0	446	Employee Health Insurance	218,655	(Indicate # of checks performed <u>7</u>)	188	
Moshe Polstien	Assist Admin	0	10,491	Employee Meals	1,730	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Trade Association dues	12,658	
See Supplemental Schedule			1,541	401K Matching Expense	6,720	Misc. Dues	3,516	
TOTAL (agree to Schedule V, line 17, col. 1)				Payroll City Tax	7,348	Subscriptions	1,120	
(List each licensed administrator separately.)			\$ 175,702	Union Pension Benefits	28,018	Advertising & Promotion	23,194	
				Other Employee Benefits	43,104	See Supplemental Schedule	3,695	
B. Administrative - Other							Less: Public Relations Expense ()	
Description			Amount				Non-allowable advertising (23,194)	
Management Fees - Nucare Services Corp.			\$ 987,987				Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 987,987	TOTAL (agree to Schedule V, line 22, col.8)			\$ 824,509	
(Attach a copy of any management service agreement)							TOTAL (agree to Sch. V, line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Frost, Ruttenburg, & Rothblatt	Accounting		\$ 20,596				Out-of-State Travel	\$
CDW Computer Centers	Computer Expense		782					
Emdeon Business Services	Computer Expense		3,295					
Giftrap	Computer Expense		6,140				In-State Travel	
Health Data Systems	Computer Expense		7,753					
Growth Design Corp.	Business Consultant		477					
Personnel Planners	Unemployment Consult.		4,089					
See Attached	Legal		107,080				Seminar Expense	3,703
PSD Solutions	Computer Expense		5,790				Allocation from Nucare	2,462
Settlement of Lawsuit	Legal		112,000					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			Entertainment Expense ()	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 268,003				(agree to Sch. V, line 24, col. 8)	\$ 6,165

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number California Gardens N & Rehab C

Report Period Beginning: 01/01/07 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab C

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 \$12,658
- (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? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 27,880 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 162,608
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 1,730 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT