



Facility Name & ID Number California Gardens N & Rehab Ctr

# 0040022 Report Period Beginning: 01/01/09 Ending: 12/31/09

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 Patient Days by Level of Care and Primary Source of Payment				5	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	<u>92,278</u>	<u>1,459</u>	<u>7,849</u>	<u>101,586</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>92,278</u>	<u>1,459</u>	<u>7,849</u>	<u>101,586</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.71%

D. How many bed-hold days during this year were paid by the Department? 3,097 (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 5,447

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: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	394,618	113,178	14,220	522,016		522,016		522,016		1
2	Food Purchase		488,975		488,975	(1,752)	487,223	(3,204)	484,019		2
3	Housekeeping		47,360	485,645	533,005		533,005		533,005		3
4	Laundry		15,596	2,513	18,109		18,109		18,109		4
5	Heat and Other Utilities			248,815	248,815		248,815	3,059	251,874		5
6	Maintenance	224,239	51,516	147,007	422,762		422,762	22,220	444,982		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	618,857	716,625	898,200	2,233,682	(1,752)	2,231,930	22,075	2,254,005		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			51,600	51,600		51,600		51,600		9
10	Nursing and Medical Records	3,711,365	268,648	25,989	4,006,002		4,006,002	(41,644)	3,964,358		10
10a	Therapy	58,782	(1,578)	968	58,172		58,172		58,172		10a
11	Activities	72,943	20,470	2,109	95,522		95,522		95,522		11
12	Social Services	91,247		44,738	135,985		135,985		135,985		12
13	CNA Training										13
14	Program Transportation	104,815		14,578	119,393		119,393		119,393		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,039,152	287,540	139,982	4,466,674		4,466,674	(41,644)	4,425,030		16
	<b>C. General Administration</b>										
17	Administrative	190,374		978,246	1,168,620		1,168,620	(955,235)	213,385		17
18	Directors Fees										18
19	Professional Services			175,675	175,675	(7,803)	167,872	(15,936)	151,936		19
20	Dues, Fees, Subscriptions & Promotions			110,653	110,653		110,653	(67,023)	43,630		20
21	Clerical & General Office Expenses	368,532	69,034	838,330	1,275,896		1,275,896	(581,109)	694,787		21
22	Employee Benefits & Payroll Taxes			948,471	948,471	1,752	950,223	(18)	950,205		22
23	Inservice Training & Education										23
24	Travel and Seminar			12,807	12,807		12,807	(4,286)	8,521		24
25	Other Admin. Staff Transportation			1,218	1,218		1,218	1,399	2,617		25
26	Insurance-Prop.Liab.Malpractice			301,086	301,086		301,086	18,341	319,427		26
27	Other (specify):*							52,265	52,265		27
28	<b>TOTAL General Administration</b>	558,906	69,034	3,366,486	3,994,426	(6,051)	3,988,375	(1,551,603)	2,436,772		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,216,915	1,073,199	4,404,668	10,694,782	(7,803)	10,686,979	(1,571,171)	9,115,808		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 &amp; ID Number

California Gardens N &amp; Rehab Ctr

#0040022

Report Period Beginning:

01/01/09

Ending:

12/31/09

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			145,377	145,377		145,377	229,416	374,793			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			73,644	73,644		73,644	727,170	800,814			32
33	Real Estate Taxes					7,803	7,803	338,529	346,332			33
34	Rent-Facility & Grounds			2,489,117	2,489,117		2,489,117	(2,488,573)	544			34
35	Rent-Equipment & Vehicles			9,307	9,307		9,307	4,675	13,982			35
36	Other (specify):*							70,413	70,413			36
37	<b>TOTAL Ownership</b>			2,717,445	2,717,445	7,803	2,725,248	(1,118,371)	1,606,877			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	77,166	342,831	559,011	979,008		979,008		979,008			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):*	97,460		243	97,703		97,703	(97,703)				43
44	<b>TOTAL Special Cost Centers</b>	174,626	342,831	721,862	1,239,319		1,239,319	(97,703)	1,141,616			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,391,541	1,416,030	7,843,975	14,651,546		14,651,546	(2,787,245)	11,864,301			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	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	(7,800)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(75,960)	30		9
10	Interest and Other Investment Income	(103)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(70)	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	(1,370)	21		18
19	Entertainment	(5,226)	24		19
20	Contributions	(18,050)	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	(759,317)	21		24
25	Fund Raising, Advertising and Promotional	(40,657)	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	(408,051)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (1,316,604)		\$	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)	(1,470,641)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (1,470,641)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (2,787,245)		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				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

California Gardens N & Rehab Ctr

ID# 0040022

Report Period Beginning: 01/01/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Veterans Expense	\$ (62,418)	10	1
2	Patient Needs	(9,485)	10	2
3	Bank Charges	(22,969)	21	3
4	Income from copies	(1,131)	21	4
5	Food Rebates	(3,134)	02	5
6	Jury Duty	(86)	10	6
7	Marketing Employee Benefit	(18)	22	7
8	Building Co-Professional Fees	(10,098)	19	8
9	Building Co- Amortization	(6,573)	36	9
10	Building Co.- Bank Fees	(1,127)	21	10
11	Building Co- License & Taxes	(6,779)	20	11
12	Prior year and not allowable legal	(19,647)	19	12
13	Annual Report	(225)	20	13
14	COPE Dues	(9,439)	20	14
15	Capitalized R&M	(5,848)	06	15
16	Marketing travel	(243)	43	16
17	Marketing Salary	(68,313)	43	17
18	Director of Guest Services	(29,147)	43	18
19	Additional R&M	16,887	06	19
20	Additional Marketing Expenses	(168,258)	17	20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(408,051)		49

California Gardens N & Rehab Ctr

ID# 0040022

Report Period Beginning: 01/01/09

Ending: 12/31/09

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

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number California Gardens N & Rehab Ctr# 0040022

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(3,204)											(3,204)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			3,059									3,059	5
6	Maintenance	3,239	8,750	10,231									22,220	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>35</b>	<b>8,750</b>	<b>13,291</b>									<b>22,075</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(71,989)			30,345								(41,644)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(71,989)</b>			<b>30,345</b>								<b>(41,644)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(168,258)		(725,348)	(61,629)								(955,235)	17
18	Directors Fees													18
19	Professional Services	(29,745)	10,098	3,376	335								(15,936)	19
20	Fees, Subscriptions & Promotions	(75,150)	6,779	1,195	153								(67,023)	20
21	Clerical & General Office Expenses	(785,914)	1,127	184,209	19,469								(581,109)	21
22	Employee Benefits & Payroll Taxes	(18)											(18)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(5,226)		751	189								(4,286)	24
25	Other Admin. Staff Transportation			735	664								1,399	25
26	Insurance-Prop.Liab.Malpractice		15,432	2,909									18,341	26
27	Other (specify):*			44,407	7,858								52,265	27
28	<b>TOTAL General Administration</b>	<b>(1,064,311)</b>	<b>33,436</b>	<b>(487,766)</b>	<b>(32,961)</b>								<b>(1,551,603)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(1,136,265)</b>	<b>42,186</b>	<b>(474,476)</b>	<b>(2,616)</b>								<b>(1,571,171)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number California Gardens N & Rehab Ctr# 0040022

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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	(75,960)	294,305	10,854	217								229,416	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(103)	720,525	6,392	355								727,170	32
33	Real Estate Taxes		328,784	9,745									338,529	33
34	Rent-Facility & Grounds		(2,489,117)	544									(2,488,573)	34
35	Rent-Equipment & Vehicles			4,675									4,675	35
36	Other (specify):*	(6,573)	76,986										70,413	36
37	<b>TOTAL Ownership</b>	<b>(82,636)</b>	<b>(1,068,517)</b>	<b>32,210</b>	<b>572</b>								<b>(1,118,371)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(97,703)											(97,703)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(97,703)</b>											<b>(97,703)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(1,316,604)	(1,026,331)	(442,265)	(2,045)								(2,787,245)	45

**VII. RELATED PARTIES**

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  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	\$ 2,489,117	California Gardens Associates	100.00%	\$	(2,489,117)	1
2	V	32 Interest	536	California Gardens Associates	100.00%	721,061	720,525	2
3	V	19 Professional Fees		California Gardens Associates	100.00%	10,098	10,098	3
4	V	30 Depreciation		California Gardens Associates	100.00%	294,305	294,305	4
5	V	36 Amortization		California Gardens Associates	100.00%	6,573	6,573	5
6	V	33 Real Estate Tax		California Gardens Associates	100.00%	328,784	328,784	6
7	V	26 Property & Liability Insurance		California Gardens Associates	100.00%	15,432	15,432	7
8	V	20 Misc Licenses & Taxes		California Gardens Associates	100.00%	6,779	6,779	8
9	V	36 MIP Expenses		California Gardens Associates	100.00%	70,413	70,413	9
10	V	06 Repairs & Maintenance		California Gardens Associates	100.00%	8,750	8,750	10
11	V	21 Bank Fees		California Gardens Associates	100.00%	1,127	1,127	11
12	V							12
13	V							13
14	Total		\$ 2,489,653			\$ 1,463,322	\$ * (1,026,331)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr# 0040022Report Period Beginning: 01/01/09Ending: 12/31/09

## 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%	\$ 3,059	\$ 3,059
16	V	6 REPAIRS AND MAINT.				10,231	10,231
17	V	17 ADMIN. - NON-OWNER				23,010	23,010
18	V	19 PROFESSIONAL FEES				3,376	3,376
19	V	20 FEES SUBSCRIPTIONS				1,195	1,195
20	V	21 CLERICAL & GENERAL				184,209	184,209
21	V	24 SEMINARS AND EDUCATION				751	751
22	V	25 ADMIN. STAFF TRAVEL				735	735
23	V	26 INSURANCE				2,909	2,909
24	V	27 EMPLOYEE BEN. GEN. ADMIN.				44,407	44,407
25	V	30 DEPRECIATION				10,854	10,854
26	V	32 INTEREST EXPENSE				6,392	6,392
27	V	33 REAL ESTATE TAX				9,745	9,745
28	V	34 PARKING LOT RENT				544	544
29	V	35 EQUIPMENT RENTAL				4,675	4,675
30	V						
31	V						
32	V						
33	V	17 ADMINISTRATIVE FEE	748,358				(748,358)
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 748,358			\$ 306,093	\$ * (442,265)

\* 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	10 CLINICAL SALARIES	\$	CLINICAL CONSULTING SERVICES, LLC	100.00%	\$ 30,345	\$ 30,345
16	V	19 PROFESSIONAL FEES				335	335
17	V	20 DUES, LICENSE & INSPECTION				153	153
18	V	21 OFFICE WAGES				18,258	18,258
19	V	21 OFFICE EXPENSE				1,211	1,211
20	V	24 CONTINUING EDUCATION / SEMINAR				189	189
21	V	25 AUTO EXPENSE				664	664
22	V	27 PAYROLL TAXES				3,373	3,373
23	V	27 OTHER EMPLOYEE BENEFITS				4,485	4,485
24	V	30 DEPRECIATION				217	217
25	V	32 INTEREST				355	355
26	V						
27	V						
28	V	17 ADMINISTRATIVE FEE	61,629				(61,629)
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 61,629			\$ 59,584	\$ * (2,045)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Workers Compensation	\$ 145,094	Diamond Insurance	100.00%	\$ 145,094	\$	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		\$ 145,094			\$ 145,094	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

Facility Name & ID Number California Gardens N & Rehab Ctr # 0040022 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	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 Ctr

# 0040022

Report Period Beginning:

01/01/09

Ending: 12/31/09

**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 Ctr

# 0040022

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS	1,224,940	13	\$ 34,570	\$ 108,405	\$ 3,059	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	1,224,940	13	115,610	108,405	10,231	2
3	17	ADMIN. - NON-OWNER	AVAIL. CENSUS DAYS	1,224,940	13	260,001	260,001	23,010	3
4	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,224,940	13	38,148	108,405	3,376	4
5	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	1,224,940	13	13,506	108,405	1,195	5
6	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	1,224,940	13	2,081,498	1,811,576	184,209	6
7	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	1,224,940	13	8,486	108,405	751	7
8	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	1,224,940	13	8,304	108,405	735	8
9	26	INSURANCE	AVAIL. CENSUS DAYS	1,224,940	13	32,870	108,405	2,909	9
10	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	1,224,940	13	501,784	108,405	44,407	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,224,940	13	122,648	108,405	10,854	11
12	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	1,224,940	13	72,233	108,405	6,392	12
13	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	1,224,940	13	110,113	108,405	9,745	13
14	34	PARKING LOT RENT	AVAIL. CENSUS DAYS	1,224,940	13	6,145	108,405	544	14
15	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	1,224,940	13	52,826	108,405	4,675	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,458,744	\$ 2,071,577	\$ 306,093	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr

# 0040022

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	CLINICAL SALARIES	AVAIL. CENSUS DAYS	1,224,940	13	\$ 342,887	\$ 108,405	\$ 30,345	1
2	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	1,224,940	13	3,780	108,405	335	2
3	20	DUES, LICENSE & INSPECTIO	AVAIL. CENSUS DAYS	1,224,940	13	1,732	108,405	153	3
4	21	OFFICE WAGES	AVAIL. CENSUS DAYS	1,224,940	13	206,311	108,405	18,258	4
5	21	OFFICE EXPENSE	AVAIL. CENSUS DAYS	1,224,940	13	13,685	108,405	1,211	5
6	24	CONTINUING EDUCATION / ST	AVAIL. CENSUS DAYS	1,224,940	13	2,134	108,405	189	6
7	25	AUTO EXPENSE	AVAIL. CENSUS DAYS	1,224,940	13	7,503	108,405	664	7
8	27	PAYROLL TAXES	AVAIL. CENSUS DAYS	1,224,940	13	38,113	108,405	3,373	8
9	27	OTHER EMPLOYEE BENEFITS	AVAIL. CENSUS DAYS	1,224,940	13	50,678	108,405	4,485	9
10	30	DEPRECIATION	AVAIL. CENSUS DAYS	1,224,940	13	2,448	108,405	217	10
11	32	INTEREST	AVAIL. CENSUS DAYS	1,224,940	13	4,013	108,405	355	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					\$ 673,284	\$ 549,198	\$ 59,585	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr

# 0040022

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Diamond Insurance

Street Address

40 Slokie Blvd., Suite 105

City / State / Zip Code

Northbrook, IL 60062

Phone Number

( 847) 599-1002

Fax Number

( )

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Workers Compensation	Direct Allocation		\$	\$		\$ 145,094	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				\$	\$		\$ 145,094	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr

# 0040022

Report Period Beginning:

01/01/09

Ending: 12/31/09

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr

# 0040022

Report Period Beginning:

01/01/09

Ending: 12/31/09

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr

# 0040022

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 Ctr

# 0040022

Report Period Beginning:

01/01/09

Ending: 12/31/09

**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 Ctr

# 0040022

Report Period Beginning:

01/01/09

Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & Rehab Ctr

# 0040022

Report Period Beginning:

01/01/09

Ending: 12/31/09

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

California Gardens N & Rehab Ctr

# 0040022

Report Period Beginning:

01/01/09

Ending:

12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	HUD Loan		X	Mortgage			\$	\$ 13,993,462		\$ 721,061	1								
2											2								
3											3								
4											4								
5	See Supplemental Schedule										5								
<b>Working Capital</b>																			
6	Shareholder Loan		X	Working Capital				3,800,000		73,644	6								
7											7								
8	See Supplemental Schedule										8								
9	TOTAL Facility Related						\$	\$ 17,793,462		\$ 794,705	9								
<b>B. Non-Facility Related*</b>																			
10	Interest Income		X							(103)	10								
11	Interst Income-Building Co		X							(536)	11								
12	Allocated from NuCare		X							6,392	12								
13	See Supplemental Schedule									355	13								
14	TOTAL Non-Facility Related						\$	\$		\$ 6,108	14								
15	TOTALS (line 9+line14)						\$	\$ 17,793,462		\$ 800,813	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 70,413 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

California Gardens N & Rehab Ctr

# 0040022

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	<b>TOTAL Long-Term</b>									7										
<b>Working Capital</b>																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Working Capital</b>									14										
<b>B. Non-Facility Related*</b>																				
15	Alloc from Clinical Consulting		X							355										
16										16										
17										17										
18										18										
19										19										
20	<b>TOTAL Non-Facility Related</b>									355										

\* 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.)







**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).  
None

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

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	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>Alloc from Nuicare</u>			<u>13,452</u>	<u>2</u>
3	<b>TOTALS</b>	<b>193,025</b>		<b>\$ 313,452</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		1981	4,471		20			205	9
10	Various		1982	2,319		20			222	10
11	Various		1983	10,829		20			1,580	11
12	Various		1984	1,410		20			277	12
13	Various		1985	17,805		20			492	13
14	Various		1986	22,863		20			6,764	14
15	Various		1987	40,100		20			13,868	15
16	Various		1988	2,787		20			2,787	16
17	Various		1989	3,024		20	139	139	1,348	17
18	Various		1990	8,652		20	433	433	3,894	18
19	Various		1991	3,892		20	195	195	1,752	19
20	Various		1993	24,138		20	1,207	1,207	10,862	20
21	Various		1994	8,195		20	410	410	3,688	21
22	Various		1995	17,230		20	863	863	12,632	22
23	Various		1996	46,848		20	2,342	2,342	31,150	23
24	Various		1997	70,702		20	3,485	3,485	44,897	24
25	Various		1998	33,854		20	1,695	1,695	19,546	25
26	Various		1999	103,092		20	5,155	5,155	54,030	26
27	Various		2000	194,600		20	9,736	9,736	95,321	27
28	Various		2001	75,921		20	3,800	3,800	32,471	28
29	Various		2002	45,162		20	3,675	3,675	27,510	29
30	Various		2003	55,404		20	4,869	4,869	32,646	30
31	Various		2004	32,890		20	1,914	1,914	10,922	31
32	Various		2005	29,515		20	3,023	3,023	13,322	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	Related Building Company (Pages 12F & 12G)	5,070,442	294,305		202,118	(92,187)	2,457,107	67
68	Related Party Allocations (Pages 12H & 12I)	161,941	5,029		5,645	616	31,972	68
69	Financial Statement Depreciation		145,377			(145,377)		69
70	TOTAL (lines 4 thru 69)	\$ 6,088,086	\$ 444,711		\$ 250,704	\$ (194,007)	\$ 2,911,265	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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 6,088,086	\$ 444,711		\$ 250,704	\$ (194,007)	\$ 2,911,265	1
2	Telephone Cables	2006	1,188		20	119	119	475	2
3	24 Vac Ccd Camera And Monitor Install	2006	1,345		20	192	192	689	3
4	Fire Alarm Boards	2006	2,183		20	312	312	1,118	4
5	Smoke Detectors And Alarms	2006	2,772		20	396	396	1,419	5
6	Musak Music, Paging System	2006	963		20	138	138	550	6
7	New Elevator Door	2006	8,521		20	852	852	2,698	7
8	Windows	2006	6,018		20	1,204	1,204	3,811	8
9	Ap Fa Check Voided (10/5/05)	2007	(6,081)		20	(608)	(608)	(1,824)	9
10	Elevator Repairs	2008	6,857		20	343	343	371	10
11	Landscape Irrigation System	2009	19,897		20	995	995	995	11
12	Install New Solid State Door Operator And Linkage Arms	2009	9,221		20	461	461	461	12
13	Laminated Cabinetry; 2 Elevators Finish In Laminate; 6 Pcs Hand	2009	15,980		20	1,199	1,199	1,199	13
14	1St Floor Corridor Signage	2009	4,146		20	138	138	138	14
15	Landscaping Design	2009	4,970		20	124	124	124	15
16	Concrete Main Entrance And Sidewalks	2009	5,450		20	45	45	45	16
17	Elevator Improvement	2009	2,900		20	12	12	12	17
18	Floor Work, Ceilings, Wall Work	2009	212,688		20	7,976	7,976	7,976	18
19	Floor Work, Ceilings, Wall Work	2009	145,278		20	4,237	4,237	4,237	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,532,382	\$ 444,711		\$ 268,839	\$ (175,872)	\$ 2,935,759	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 6,532,382	\$ 444,711		\$ 268,839	\$ (175,872)	\$ 2,935,759	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)	\$ 6,532,382	\$ 444,711		\$ 268,839	\$ (175,872)	\$ 2,935,759	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 6,532,382	\$ 444,711		\$ 268,839	\$ (175,872)	\$ 2,935,759	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)	\$ 6,532,382	\$ 444,711		\$ 268,839	\$ (175,872)	\$ 2,935,759	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 6,532,382	\$ 444,711		\$ 268,839	\$ (175,872)	\$ 2,935,759	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)	\$ 6,532,382	\$ 444,711		\$ 268,839	\$ (175,872)	\$ 2,935,759	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Building Company Information</b>								1
2	<b>Buildings:</b>								2
3		1977	4,708,760	294,305		176,340	(117,965)	2,358,094	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	Various	2004	18,253		20	1,435	1,435	7,305	9
10	Various	2005	147,095		20	14,526	14,526	68,161	10
11	Interlocking Door Parts	2007	3,821		20	191	191	573	11
12	Clear Polish Wire Glass - 3 Rooms	2007	3,148		20	157	157	472	12
13	Clear Polish Wire Glass - 1 Room	2007	485		20	24	24	73	13
14	Cooling Tower	2007	36,990		20	1,850	1,850	5,549	14
15	2 Passenger Elevator	2007	6,721		20	336	336	1,008	15
16	Elevator Located at 2829 S. California	2007	2,350		20	118	118	353	16
17	Smoke Detectors and Standard Wire Bases	2007	3,509		20	175	175	526	17
18	Motor - Cooling Tower	2007	4,110		20	206	206	617	18
19	Electrical Work	2007	17,065		20	853	853	2,560	19
20	Carpet; Armstrong Beckford	2008	7,103		20	355	355	710	20
21	Remote Annunciator Panel for Basement Generator	2008	3,852		20	193	193	386	21
22	Outdoor Lighting Fixtures	2008	2,200		20	110	110	220	22
23	Clear Insulated Glass	2008	1,245		20	62	62	124	23
24	Video Monitoring System	2008	3,713		20	186	186	372	24
25	Outdoor Lighting	2008	8,415		20	421	421	842	25
26	CCTV to Monitor Floors	2008	3,469		20	173	173	346	26
27	Varieties of Burning Bushes	2008	8,175		20	409	409	818	27
28	Installation of Video Multiplexer Recorder	2008	2,710		20	136	136	272	28
29	Dome Camera and Quad Video Control	2008	1,265		20	63	63	126	29
30	Asphalt Paving Work	2008	4,350		20	218	218	436	30
31	Headend Installation and Home Run Wiring to Roof	2008	26,078		20	1,304	1,304	2,608	31
32	Change Heights of Outlets	2008	2,625		20	131	131	262	32
33	Tadiran IPx500 Telephone System	2008	42,935		20	2,147	2,147	4,294	33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 5,070,442	\$ 294,305		\$ 202,118	\$ (92,187)	\$ 2,457,107	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Related Party Information</b>		\$	\$		\$	\$		1
2	<b>Buildings:</b>								2
3	Allocated from NuCare 7257 N Lincoln Ave	2004	114,694	2,941	35	3,277	336	20,071	3
4	Allocated from Clinical Consulting Srvs 7257 N. Lincoln Ave	2004	6,372	163	35	182	19	1,115	4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	Allocated from NuCare 7257 N Lincoln Ave	2004	2,279	131	20	116	(15)	638	9
10	Allocated from NuCare 7257 N Lincoln Ave	2005	10,456	827	20	675	(152)	2,909	10
11	Allocated from Clinical Consulting Srvs 7257 N. Lincoln Ave	2004	127	7	20	6	(1)	35	11
12	Allocated from Clinical Consulting Srvs 7257 N. Lincoln Ave	2005	581	46	20	37	(9)	162	12
13	Allocated from NuCare	2003	1,037	35	20	52	17	317	13
14	Allocated from NuCare	2004	21,045	701	20	1,054	353	6,015	14
15	Allocated from NuCare	2005	1,248	42	20	62	20	303	15
16	Allocated from NuCare	2006	1,692	56	20	85	29	285	16
17	Allocated from NuCare	2008	1,783	59	20	89	30	112	17
18	Allocated from NuCare	2009	627	21	20	10	(11)	10	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)	\$ 161,941	\$ 5,029		\$ 5,645	\$ 616	\$ 31,972	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number California Gardens N & Rehab Ctr

# 0040022

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	\$ 891,288	\$ 4,269	\$ 89,380	\$ 85,111	10	\$ 528,767	71
72	Current Year Purchases	193,663	1,772	15,893	14,121	10	15,893	72
73	Fully Depreciated Assets	183,220		680	680	10	183,220	73
74								74
75	TOTALS	\$ 1,268,171	\$ 6,041	\$ 105,953	\$ 99,912		\$ 727,880	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)	\$ 8,135,166	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 450,752	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 374,792	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (75,960)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,684,799	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	Alloc from NuCare				544			5
6								6
7	TOTAL				\$ 544			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 13,982 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_/2009 \$ \_\_\_\_\_

13. \_\_\_\_\_/2010 \$ \_\_\_\_\_

14. \_\_\_\_\_/2011 \$ \_\_\_\_\_

\* 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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8		
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units	Cost			Units	Cost									
1	Licensed Occupational Therapist	39 - 03	hrs	\$				\$ 188,543							\$ 188,543	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					95,987							95,987	2	
3	Licensed Recreational Therapist		hrs													3	
4	Licensed Physical Therapist	39 - 03	hrs					227,262							227,262	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							239,105					239,105	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10	
11	Academic Education		hrs													11	
12	Other (specify):															12	
13	Other (specify): <u>See Supplemental</u>				77,166			47,219		103,726					228,111	13	
14	<b>TOTAL</b>				\$ 77,166			\$ 559,011		\$ 342,831					\$ 979,008	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

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

As of **12/31/09**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 400	\$ 312,562	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	2,487,333	2,603,179	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	135,475	135,475	6
7	Other Prepaid Expenses	276,782	338,493	7
8	Accounts Receivable (owners or related parties)	2,095,767	2,095,767	8
9	Other(specify): <u>See Attached Schedule</u>	8,953	630,955	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 5,004,710</b>	<b>\$ 6,116,431</b>	<b>10</b>
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,151,920	13
14	Buildings, at Historical Cost		3,973,900	14
15	Leasehold Improvements, at Historical Cost	1,194,354	6,630,705	15
16	Equipment, at Historical Cost	1,015,572	1,864,916	16
17	Accumulated Depreciation (book methods)	(1,332,489)	(6,632,237)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		195,561	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>	17,651	17,651	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 895,088</b>	<b>\$ 7,202,416</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 5,899,798</b>	<b>\$ 13,318,847</b>	<b>25</b>

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 957,509	\$ 957,510	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	464,534	464,534	30
31	Accrued Taxes Payable (excluding real estate taxes)	31,243	31,243	31
32	Accrued Real Estate Taxes(Sch.IX-B)		342,361	32
33	Accrued Interest Payable		59,705	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	9,880	9,880	35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>		7,731	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 5,262,039</b>	<b>\$ 5,784,195</b>	<b>38</b>
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,993,462	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$</b>	<b>\$ 13,993,462</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 5,262,039</b>	<b>\$ 19,777,657</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 637,759</b>	<b>\$ (6,458,810)</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 5,899,798</b>	<b>\$ 13,318,847</b>	<b>48</b>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,540,555</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Additional Bad Debts</b>	(125,000)	<b>3</b>
<b>4</b>	<b>Medicare Bad Debts</b>	4,560	<b>4</b>
<b>5</b>	<b>Amortization of Goodwill</b>	(74,129)	<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,345,986</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(508,227)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(200,000)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(708,227)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>637,759</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number California Gardens N &amp; Rehab Ctr

# 0040022

Report Period Beginning: 01/01/09

Ending: 12/31/09

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 12,749,467	1
2	Discounts and Allowances for all Levels	(251,607)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 12,497,860	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,035,223	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,035,223	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	433,592	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	35,032	19
20	Radiology and X-Ray	5,350	20
21	Other Medical Services	101,117	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 575,091	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	10	24
25	Interest and Other Investment Income***	103	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 113	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	35,032	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 35,032	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 14,143,319	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,233,682	31
32	Health Care	4,466,674	32
33	General Administration	3,994,426	33
<b>B. Capital Expense</b>			
34	Ownership	2,717,445	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,076,711	35
36	Provider Participation Fee	162,608	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 14,651,546	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(508,227)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (508,227)	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 Ctr

# 0040022

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	1,957	2,326	\$ 134,144	\$ 57.67	1
2	Assistant Director of Nursing	1,853	2,110	92,778	43.97	2
3	Registered Nurses	31,594	34,889	1,080,527	30.97	3
4	Licensed Practical Nurses	42,414	45,312	1,112,708	24.56	4
5	CNAs & Orderlies	88,230	97,552	1,052,582	10.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,763	5,763	58,782	10.20	8
9	Activity Director					9
10	Activity Assistants	6,773	7,496	72,943	9.73	10
11	Social Service Workers	3,224	3,530	91,247	25.85	11
12	Dietician	3,970	4,497	96,751	21.51	12
13	Food Service Supervisor					13
14	Head Cook	7,871	8,855	126,274	14.26	14
15	Cook Helpers/Assistants	16,698	18,538	171,593	9.26	15
16	Dishwashers					16
17	Maintenance Workers	12,748	13,665	224,239	16.41	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,948	2,126	138,518	65.15	20
21	Assistant Administrator	1,081	1,200	22,981	19.15	21
22	Other Administrative	406	443	28,875	65.18	22
23	Office Manager					23
24	Clerical	18,042	18,698	368,532	19.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	11,093	11,828	169,564	14.34	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,421	4,944	69,062	13.97	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	13,227	14,876	279,441	18.78	33
34	TOTAL (lines 1 - 33)	273,313	298,648	\$ 5,391,541 *	\$ 18.05	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	316	\$ 14,220	01-03	35
36	Medical Director	Monthly	51,600	09-03	36
37	Medical Records Consultant	Monthly	7,749	10-03	37
38	Nurse Consultant	458	11,450	10-03	38
39	Pharmacist Consultant	Monthly	6,790	10-03	39
40	Physical Therapy Consultant	2	90	10a-03	40
41	Occupational Therapy Consultant	3	113	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	45	10a-03	43
44	Activity Consultant	37	2,109	11-03	44
45	Social Service Consultant	785	44,738	12-03	45
46	Other(specify)				46
47	<u>Therapy Consultant</u>	16	720	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	1,618	\$ 139,624		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

**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	\$ 138,518	Workers' Compensation Insurance	\$ 145,094	IDPH License Fee	\$ 2,095		
Moshe Polestien	Assit Admin	0	22,981	Unemployment Compensation Insurance	71,557	Advertising: Employee Recruitment	11,052		
Kathleen Brander	Dir of Reg. Mgmt	0	8,928	FICA Taxes	391,927	Health Care Worker Background Check			
Marilyn Flaherty	VP of MC Reimb	0	19,946	Employee Health Insurance	251,506	(Indicate # of checks performed <u>558</u> )	6,531		
				Employee Meals	1,752	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Subscriptions	1,396		
				City Payroll Taxes	8,429	IL Council on LTC	13,711		
				Union Pension Benefits	28,636	II Association of HC Facilities	3,564		
				Dental Insurance	7,541	Licenses & Fees	3,933		
				Employee benefits	37,958	See Supplemental Schedule	1,348		
				101k Matching Expenses	5,805	Less: Public Relations Expense	( )		
						Non-allowable advertising	( )		
						Yellow page advertising	( )		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
\$ 190,373				\$ 950,205			\$ 43,630		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Administrative Fee-NuCare Services Corp			\$ 748,358				Out-of-State Travel	\$	
Administrative Fee-Quest (Adjusted out on Page 5A)			168,258						
Administrative Fee-CCS			61,629				In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense		7,581
\$ 978,245				\$			Allocated from NuCare		751
							Allocated from Clinical Consult		189
							Entertainment Expense		( )
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL		\$ 8,521
\$ 175,675									

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

\*\*See instructions.

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number California Gardens N &amp; Rehab Ctr

# 0040022

Report Period Beginning: 01/01/09

Ending: 12/31/09

**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. ILCTLC \$13711
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? 10yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 35,807 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. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 162,608  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 1,752 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? N/A If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100%in 14  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.